MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

07740

CERTIFICATE OF DEATH

★ Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: middle River.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
306 Harding ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Balto.
City or town: middle River.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 306 Harding Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna May Adams

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Samuel Howard Adams
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 3 - 1885

8. AGE:

Years	Months	Days	If less than one day
61			..... hrs. ..... min.

9. Birthplace: Balto.
(Town, county, and state)
10. Usual occupation: At Home.
11. Industry or business
FATHER 12. Name: John Crumbie
13. Birthplace: Unknown.
MOTHER 14. Maiden name:
15. Birthplace
16. Informant: Howard Adams, Son
Address: 306 Harding Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/21/46 (month) (day) (year)
Cemetery or crematory: Ebenezer, Chase.
Location
18. Funeral director: J. Connelly.
Address: 418 Eastern Ave, Essex 21,
19. 8/20/1946 (Date rec'd by registrar) John J. Connelly, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19, 1946, at 9:4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1946, to Aug. 19, 1946 and that I last saw h..es alive on May 13, 1946

	DURATION
Immediate cause of death: Coronary Occlusion	1 day
Due to: Coronary atherosclerosis	
Due to:	
Other conditions: Hypertensive Vascular	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. Kolodny M.D.
M. D. or other
Address: Ridge Rd. Date signed: Aug. 19, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516

CERTIFICATE OF DEATH

07741

Reg. Dist. No. 33-

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural near Freeland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs.-

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural near Freeland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1 mi North of Freeland.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Eugene Bales.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.-

6.(b) Name of husband or wife: Sarah Margaret Bales

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 11, 1876

8. AGE:

Years	Months	Days	If less than one day
70	1	18	...hrs. ...min.

9. Birthplace: ATKINS Va.-
(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business: Own Farm.-

FATHER
12. Name: Samuel Bales.
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Lumbarger
15. Birthplace: Va.

16. Informant: Harry Bales.
Address: Freeland, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1946 (month) (day) (year)

Cemetery or crematory: New Freedom Cemetery

Location: New Freedom, Pa.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. Aug 30 1946 (Date rec'd by registrar) Columbus L Fraelich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1946 to Aug 26 1946 and that I last saw him alive on Aug. 22 1946

Immediate cause of death	DURATION
Carcinoma of Prostate	1½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Louis Schatanoff M.D.
M. D. or other

Address: New Freedom, Pa. Date signed 8-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07742

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 0 mos., 8 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs. 0 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Garland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Oak Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward W. Barling

3.(b) Social Security Number: 212-01-0106

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie E. Barling
6.(c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): February 3, 1890

8. AGE:	Years	Months	Days	If less than one day
	56	6	23	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business

FATHER
12. Name: Edward G. Barling
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Lillie Bishop
15. Birthplace: Baltimore, Maryland

16. Informant: Edward W. Barling
Address: Oak Ave., Garland, Linthicum P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29, (month) (day) 1946 (year)
Cemetery or crematory: Louden Park Cemetery
Location: 3801 Frederick Rd., Balto., Md.

18. Funeral director: Wm. J. Tickner & Sons
Address: Pa. & North Ave., Balto., Md.

19. Aug. 26, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 1946 at 7:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1946, to August 26, 1946 and that I last saw him alive on August 26, 1946.

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: D. J. Siegel M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 8/26/46

Rec'd - 8-28-46 Dr E E Nichol

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

07743

Reg. Diat. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Baltimore

City or town: Rockdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Rockdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8306 Lages Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jessie A. Bell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Walter Bell.

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May. 22 1867

8. AGE:

Years	Months	Days	If less than one day
79	6.	14	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: William Folsom

13. Birthplace: Virginia

MOTHER

14. Maiden name: Jessie A. Folsom

15. Birthplace: Virginia

16. Informant: Mrs. John P. Grande.

Address: 8306 Lages Lane. Rockdale Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Aug. 6 1946

Cemetery or crematory: Mt. Olivet

Location: Ramsaystown, Md

18. Funeral director: E. Wallis Lamotte

Address: 4510 Liberty Heights Ave

19. (Date rec'd by registrar) Aug 6 1946 Henry A. Dunnigan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 3rd 1946, at 7 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1946, to Aug 3 1946

and that I last saw her alive on Aug 3 1946

	DURATION
Immediate cause of death: Coronary Thrombosis	10 days
Due to: Arteria Sclerosis	10 yrs
Due to:	
Other conditions: Diabetes mellitus Diabetes Mellitus	20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: injured at work?

23. SIGNATURE: A. F. Semmel M. D. or other

Address: 4509 Liberty Hts Ave Date signed: Aug 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

07744 C

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 43 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 South Arlington Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: HARRY THOMAS BELT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Edna Florence Belt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-25-1891

8. AGE: Years	Months	Days	If less than one day
54	10	0	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Pipe Fitter

11. Industry or business:

FATHER 12. Name: Thomas Beltpson

13. Birthplace: Hay Market, Virginia

MOTHER 14. Maiden name: Sarah Thompson

15. Birthplace: Washington

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 28, 1946 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Park

Location: Baltimore, Md.

18. Funeral director: E. W. Thompson

Address: 1003 W. Baltimore St.

19. 8/28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1946, at 6:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 13, 1946, to August 25, 1946 and that I last saw h... 1m ...alive on August 25, 1946

Immediate cause of death	DURATION
BRONCHOPNEUMONIA	1 week
Other conditions:	
Dxx Paralytic Ileus	1 week
Dxx Ulcer, Pyloric, chronic	2 years
Other conditions Intestinal obstruction, partial	6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D., CLIN. D. DIR.

Address: V.A.H. FT. HOWARD, MD. Date signed: 8-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

24[illegible] W. Charles St., Baltimore

93d C7745

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Balto

City or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balto

City or town Woodstock

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma Cecilia Bennett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C.	married

6.(b) Name of husband or wife Gabriel A Bennett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 23rd 1873

8. AGE:

Years	Months	Days	If less than one day
72	8	2	..... hrs. ..... min.

9. Birthplace St. Marys County (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Peter Jones

FATHER 13. Birthplace St Marys County

MOTHER 14. Maiden name Mary Weldon

MOTHER 15. Birthplace St. Mary's County

16. Informant Gabriel A Bennett

Address Woodstock Balto Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28 1946 (month) (day) (year)

Cemetery or crematory St Alphonsus

Location Woodstock Balto Co. Md

18. Funeral director F C Hegnbothom

Address Ellicott City Md

19. Aug 26 1946 (Date rec'd by registrar) Wm. E. Martin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1946 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946 to Aug 25 1946 and that I last saw h[illegible] alive on August 24 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	5 days
Due to Hypertension Heart disease	7
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ernest W Lemmon M.D. M. D. or other

Address Ellicott City Md Date signed Aug 26 1946

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07746

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years, 6 mos., 27 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 15 years, 6 mos., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Pauline Blake

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

6.(b) Name of husband or wife: ? Sam Blake

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	21	hrs. min.

9. Birthplace: Riga, Russia (Town, county, and state)

10. Usual occupation: Tailoress

11. Industry or business: Clothes

FATHER 12. Name: Jacob Blake

FATHER 13. Birthplace: Europe

MOTHER 14. Maiden name: Emma Rosengarten

MOTHER 15. Birthplace: Europe

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-46 (month) (day) (year)

Cemetery or crematory: Rosedale

Location: Shula Rd & Hamilton Ave

18. Funeral director: Jack Lewis Inc

Address: 1429 E. Balto St

19. 8-27 (Date received by registrar) 1946 Harry A. Miller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1946, at 6:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1931 to August 27 1946 and that I last saw her alive on August 27 1946

Immediate cause of death	DURATION
Acute cardiac failure	sudden
Due to: Hypertensive cardiovascular disease	indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.

Address: Catonsville-28, Md. M. D. or other Date signed: 8-27-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07747 8

Reg. Dist. No. 30

1. PLACE OF DEATH
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Hood Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County B
City or town Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1333 James St.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME JOSEPHINE K. BRANDT

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Emil P. Brandt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 16, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	19	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation:
11. Industry or business:
12. FATHER — Name: John Deckelmann
13. Birthplace: Germany
14. MOTHER — Maiden name: - Kapraun
15. Birthplace: Germany
16. Informant: Mr. Edward E. Brandt
Address: 1333 James St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.
19. 8/6 (Date rec'd by registrar) 19 46 A. W. Stelmack Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 5, 19 46 at 6:30A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6 1946, to August 5 1946, and that I last saw h.. alive on Aug 4 1946

Immediate cause of death	DURATION
Due to: Chr. Myocarditis	9 yrs
Due to: Chr. Interstitial nephritis	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Brown M. D. or other
Address: 1634 N. Monroe Date signed 8/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32 — 17748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1936
Hospital, institution, or street address where death occurred: Augsburg Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County:
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
Street No.: Campfield Rd. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sena Bubenheim — **3.(b) Social Security Number:**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Dec 28. 1872

8. AGE: Years: 73 | Months: 7 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Peter Bubenheim
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Christina
MOTHER 15. Birthplace: Unknown
16. Informant: Records Augsburg Home
Address: Campfield Rd
17. Burial (Burial, cremation, or removal? Which?) Date thereof 8-16-46. (month) (day) (year)
Cemetery or crematory: Balto Cem.
Location: E. North Ave.
18. Funeral director: L. Heemann & Son
Address: 32 S. Broadway
19. 8/14 1946 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 14. 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946, to Aug 14 1946; and that I last saw h.e.s. alive on August 13th 1946.

	DURATION
Immediate cause of death: (a) – Arteriosclerosis – Coronary Thrombosis	5 yrs.
Due to: –	
Due to: Hemorrhagic Arteriosclerosis –	?
Other conditions: – Senile Psychosis.	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Earl L. Chambers M. D. or other
Address: 4108 Liberty Hts. Ave. Date signed 8/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

C7749

Reg. Dist. No. 44

1. PLACE OF DEATH:

County BALTO.

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
700 EASTERN AVE ESSEX 21

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County BALTO

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No. 700 EASTERN AVE ESSEX 21
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME THERESA BUEDEL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife FRANK J.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 6 1869

8. AGE: Years	Months	Days	If less than one day
77	-	4	hrs. min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation

11. Industry or business AT HOME

FATHER
12. Name LINK
13. Birthplace GERMANY

MOTHER
14. Maiden name KATHERINE SCHISSLER
15. Birthplace GERMANY

16. Informant JOSEPH BUEDEL

Address 700 EASTERN AVE ESSEX 21

17. BURIAL Date thereof AUG 14 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory HOLY REDEEMER

Location 4300 BELAIR ROAD

18. Funeral director MARTIN W.E. DIPPEL'S SONS

Address LOMBARD - ANN STS

19. Aug 13 1946 John D. Lomelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 10 1946, at 4:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st 1945, to August 10 1946
and that I last saw her alive on August 10 1946

Immediate cause of death — DURATION

Carcinoma of Stomach — 2yrs.

Due to

Due to

Other conditions none

(Includo pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James F. White M.D.
M. D. or other

Address 7601 Eastern Ave Baltimore 24, Md. Date signed 8/11/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

7601 E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-d

CERTIFICATE OF DEATH

[illegible] 7750 14 Reg. Dist. No.

1. PLACE OF DEATH:
County Balto.
City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Edgemere
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2326 Ruth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John T. Burgess Sr.

3.(b) Social Security Number 213-07-3532 213-07-3532

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Eleanor F. Burgess nee Downing 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 2 - 1884

8. AGE: Years 62 Months 5 Days 0 If less than one day ..... hrs. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation Machenist

11. Industry or business Beth Steel (Yd Pa Plant)

FATHER 12. Name Robert Burgess

FATHER 13. Birthplace Delaware

MOTHER 14. Maiden name Anna Callahan

MOTHER 15. Birthplace Delaware

16. Informant Mrs. Eleanor Burgess

Address 2326 Ruth Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 5 - 46 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Eastern Ave.

18. Funeral director John G. Connelly

Address 418 Eastern Ave.

19. Aug 5 1946 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1946 at 12 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1946, to August 2 1946

and that I last saw h... alive on August 1 1946

Immediate cause of death ..... DURATION

Carcinoma Lung Lft 1 Yrs

Due to.....

Due to.....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. R. Lindsay M.D. M. D. or other

Address 520 S. Ponca St. Baltimore 24 Md. Date signed 8-2-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 07751 Reg. Dist. No. 37

1. PLACE OF DEATH:
County Balto.
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Cockeysville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Nicholas Woodward Butler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widowed

B.(b) Name of husband or wife Florence Addie Lee
B.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 17, 1863

8. AGE: Years 82 | Months 9 | Days 6 | If less than one day ____ hrs. ____ min.

9. Birthplace Balto City, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Nicholas Butler
13. Birthplace unknown

MOTHER
14. Maiden name Fannie Woodward
15. Birthplace unknown

16. Informant Mrs. Willard S. Lee
Address Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 (month) 22 (day) 1946 (year)
Cemetery or crematory Parkwood Cemetery
Location Balto., Md.

18. Funeral director J. Scott Brooks
Address Sparks, Md.

19. Aug. 19 1946 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1946, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1943, to Aug 18 1946
and that I last saw him alive on Aug 16 1946

Immediate cause of death	DURATION
Myocarditis.	3 yrs.
Due to arterio sclerosis.	
Due to senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

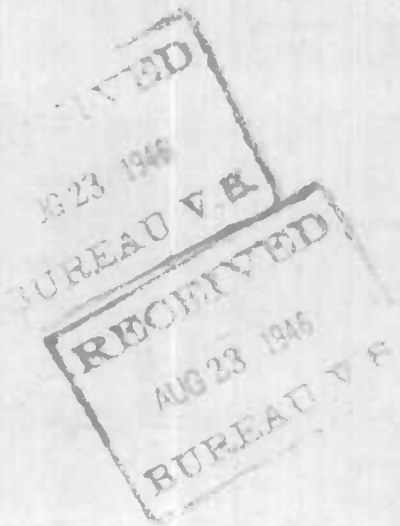
23. SIGNATURE Wilmer C. Ensor M. D. or other
Address Cockeysville Md Date signed 8/19/46.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M)


RECEIVED
AUG 23 1946
BUREAU V-B
RECEIVED
AUG 23 1946
BUREAU V-F

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

CERTIFICATE OF DEATH

67752

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Garrison, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5640 Govane Ave

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Wm F. Cantler

3.(b) Social Security Number None

4. Sex M.

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary Elliott

6.(c) If alive, give age ...... years

7. Birth date of deceased (mo., day, yr.) May 5. 1872

8. AGE: Years 74 Months 3 Days 20 If less than one day ...... hrs. ...... min.

9. Birthplace Harford Co. Md.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name John Henry Cantler

13. Birthplace Harford Co. Md

MOTHER 14. Maiden name Amanda Ritchie

15. Birthplace Harford Co. Md

16. Informant Mary F. Cantler

Address 5640 Govane Ave

17. Burial Date thereof 8/28/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion

Location Harford Co. Md.

18. Funeral director Witthoeft & Kline Inc

Address 1217 St. Louis St

19. Aug 46 19 ...... Carl Hedeman Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1946, at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 25 1946 to Aug 25 1946

and that I last saw him dead alive on Aug 25 1946

Immediate cause of death Crushed Chest. Internal Hemorrhage

Due to Compound Fracture of Rt Leg. Lacerations of rt. hand & scalp

Due to auto accident.

DURATION 10 min.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident. Date of Aug 25 '46

Where did injury occur? Garrison Balto. Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Struck by auto. Injured at work?

23. SIGNATURE D. A. Caples M.D. Med. Examiner

M. D. or other

Address Reisterstown, Md. Date signed 8-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 7753 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 7 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 806 E. 22nd Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roland Ross Carmine

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Alma H. Hoddinott 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1875

8. AGE: Years 71 Months 2 Days 4 If less than one day hrs. min.

9. Birthplace Maryland, East New Market (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Carpentering

FATHER 12. Name Shadrach Carmine

13. Birthplace Caroline Co., Maryland

MOTHER 14. Maiden name Sarah Willoughby

15. Birthplace Dorchester Co., Md.

16. Informant Hospital records

Address Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/24/46 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Baltimore Md

18. Funeral director Wilbur Cook Co.

Address 1217 St Paul St.

19. 8/23/46 A.W. Hedrick (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22 1946, to August 22 1946 and that I last saw him alive on August 22 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	12 hrs.
Due to Hypertensive arteriosclerotic-renal disease	indef.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 8-22-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 17754

1. PLACE OF DEATH:
County: Baltimore
City or town: Ft. Howard.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.
How long in hospital or institution? 23 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1715 Druid Hill Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: PRINCE C. CHRISTY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

8.(b) Name of husband or wife: Widower
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 2-6-1892

8. AGE: Years	Months	Days	If less than one day
54	5	17	hrs. min.

9. Birthplace: Miami, Fla. (town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Frank Christy
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Florida

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-27-46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Charles R. Law
Address: 802 Madison Ave., Balto., Md.

19. 8/27/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1946, at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31, 1946, to August 23, 1946
and that I last saw him alive on August 23, 1946

Immediate cause of death	DURATION
Tuberculosis, pulmonary, chronic far advanced, active IV	Unknown
Due to:	
Due to:	
Other conditions: Tuberculous laryngitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M Cullison M.D. or other
R. M. CULLISON, M.D. CLIN. DIR.
Address: V.A. Ft. Howard, Md. Date signed: 8-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

"

Helen Hall
831 W. Lafayette

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B&A)

CERTIFICATE OF DEATH

07753

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Baltimore
City or town Edgemere
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
2511 Pac Lane
Stay in hospital or inst. (yrs., or mos., or days) none
Stay in this community (yrs., or mos., or days) 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Sparrows Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2511 Pac Lane
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Virginia E. Cox

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Montressor Cox
6(c) if alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1865

8. AGE: Years	Months	Days	If less than one day
81	2	16	hrs. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual occupation housewife
11. Industry or business
FATHER 12. Name Walter Price
13. Birthplace Virginia
MOTHER 14. Maiden name ? Bowman
15. Birthplace Virginia
16. Informant Mrs. Pet Mahoney
Address 2500 Lakeview Ave., Sparrows Pt., 19
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/46 (month) (day) (year)
Cemetery or ~~crematory~~ Family cemetery at Wilhoit, Va.
Location Wilhoit, Va.
18. Funeral director John O. Mitchell & Sons, Inc.
Address 1900 Eutaw Place, Baltimore - 17 - Md.
19. 8/2 19 46 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 46, at 7a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 19 46, to Aug 1 19 46, and that I last saw her alive on July 31 19 46

Immediate cause of death	DURATION
Cerebral hemorrhage.	3 days
Due to Arteriosclerosis generalized.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. R. Lindsay M.D.
M. D. or other
Address 520 D St. Sparrows Pt. Md. Date signed 8-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P
C7756
Reg. Dist. No. 31

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Baltimore Co.
County Hiltop & Dorchester Rd.
City or town Woodlawn Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hiltop & Dorchester Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

MARY DICHIARE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	W.

6.(b) Name of husband or wife: late Salvatore Dichiare
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5 1870

8. AGE: Years	Months	Days	If less than one day
76	3	1	..... hrs. ..... min.

9. Birthplace: Cefalu Italy
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER
12. Name: Rosario Marsiglia
13. Birthplace: Italy

MOTHER
14. Maiden name: Salvatora Raimondo
15. Birthplace: Italy

16. Informant: Katie Palmerino (Daughter)
Address: Hiltop & Dorchester Rd. Woodlawn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 8 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem.
Location: Old Frederick Rd.

18. Funeral director: Frank Della Rose
Address: 52 N. Morley St.

19. 8/7 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 1946, at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1946, to August 6 1946
and that I last saw h... alive on August 5 1946

	DURATION
Immediate cause of death: Cerebral hemmorhage	8 da.
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chester Riland M.D.
M. D. or other
Address: 2532 Edmondson Ave. Date signed: 8-7-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07757

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural Near Parkton.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural near Parkton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 mi North of Parkton.

(If rurel, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bettie Dickmyer.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife: Henry Dickmyer

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): December 9, 1861.

8. AGE:

Years	Months	Days	If less than one day
84	8	20	...hrs. ...min.

9. Birthplace: Finksburg, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home.

FATHER

12. Name: Benjamin F. Price.

13. Birthplace: Mt. Carmel, Md.

MOTHER

14. Maiden name: Mary Hershberger

15. Birthplace: Unknown.

16. Informant: Henry Dickmyer

Address: Parkton, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1946 (month) (day) (year)

Cemetery or crematory: Stiltz Cemetery.

Location: Glen Rock, Pa. R.D.

18. Funeral director: Jacob Hartenstein

Address: New Freedom, Pa.

19. Aug 30 1946 (Date rec'd by registrar) Charles L. Fuller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1940, to Aug 29 1946 and that I last saw h... alive on Aug. 29 1946

Immediate cause of death	DURATION
Cerebral Thrombosis	3 days
Due to	
Due to	
Other conditions: Pulmonary Tuberculosis Hypertension arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Frames M. D. or other

Address: Parkton, Md. Date signed: 8-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07758

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 0 mos., 6 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3 N. Exeter Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lowell Watson Dobbins

3.(b) Social Security Number: # Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 27, 1926

8. AGE:	Years	Months	Days	If less than one day
	19	11	8	hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: John Dobbins

13. Birthplace: Lawrence Co., Kentucky

MOTHER — 14. Maiden name: Ruby Webb

15. Birthplace: Portsmith, Ohio

16. Informant: Ruby Dobbins

Address: 3 N. Exeter St., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 8, 1946 (month) (day) (year)

Cemetery or crematory: Logan Cemetery

Location: Logan, West Virginia

18. Funeral director: Frank H. Newell Inc.

Address: Pikesville, Maryland

19. Aug. 4, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd 8-7-46 E.R.

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH: August 4, 1946, at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 29, 1946, to August 4, 1946 and that I last saw h... im... alive on August 4, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mt. Wilson, Md. Date signed: 8/4/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

C7759

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or towo limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Summit Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No. Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Benjamin L. Dowell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Frances V. Dowell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct, 1862

8. AGE: Years	Months	Days	If less than one day
83	10		hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: John Dowell
13. Birthplace: Md.

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Miss Ruth Dowell
Address: Halethorpe. Md.

17. Burial 29/46 Date thereof Aug. 29/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Lorraine Pk. Balto. Md.
Location: Woodlawn, Md.

18. Funeral director: Harry F. Nitkie
Address: 410 E. Edmondson Ave

19. Aug. 29 1946 C. W. Hedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1946, at 11.45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1946 to Aug 26 1946
and that I last saw him alive on Aug 22 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 Days
Due to: Cerebral Arteriosclerosis	4 yrs
Due to: Coronary Sclerosis	12 yrs
Other conditions: Senility	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: B. A. Brumbaugh M. D. or other
Address: Edgewood Md. Date signed 8/29/46

Rev. Brumbaugh
Main St. Elkridge

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07760

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Catonsville Nursing Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4637 Tokeby Road.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Mary Mowney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb. 13. 1865

8. AGE: Years	Months	Days	If less than one day
81	6	14	hrs. min.

8. Birthplace: Va.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Joseph Mowney

13. Birthplace: Ireland

MOTHER 14. Maiden name: Johanna Monnaghue

15. Birthplace: Ireland

16. Informant: Miss Angela M. O'Neill

Address: 4637 Tokeby Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug. 30 46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: 4300 Old Frederick Rd.

18. Funeral director: Harry F. Kirkley

Address: 4101 Edmondson ave

19. Aug. 29 1946 (Date rec'd by registrar) Alo Fredrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/17 1944, to 8/27 1946 and that I last saw her alive on 8/26 1946

	DURATION
Immediate cause of death: Bronchopneumonia	12 hrs.
Due to: Arteriosclerosis	?
Due to: Senility	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert A. Reiter, M.D. M. D. or other

Address: 3408 W Under Ave Date signed: 8/28/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

07761

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baltimore City Hospitals
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Dennis Finn

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1871

8. AGE: Years	Months	Days	If less than one day
75	-	23	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Laborer (years ago.)

11. Industry or business: Unknown

FATHER
12. Name: Patty Finn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Johanna ?
15. Birthplace: Ireland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 7, 1946 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 8-7 1946 (Date received by registrar) Harry J. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 1946, at 4:55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946, to August 5 1946 and that I last saw him alive on August 5 1946

Immediate cause of death	DURATION
Coronary sclerosis	Indefinite
Chronic myocarditis	"
Due to: Hypertensive cardiovascular disease	"
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuerk, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 8-6-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-5)

07762

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs., 1 month, 26 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 22 yrs., 1 month, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 North Calvert
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel Foster

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 17, 1879

8. AGE: Years	Months	Days	If less than one day
66	10	22	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business: Barbering

FATHER
12. Name: William Foster
13. Birthplace: Baltimore

MOTHER
14. Maiden name: Mollie Whittington
15. Birthplace: Maryland

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 9-23-46
(month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 9/23 19 46
(Date received by registrar)
Harry W. Miller
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 19 46, at 6:15 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13 19 34, to August 8 19 46 and that I last saw him alive on August 8 19 46

Immediate cause of death	DURATION
Malnutrition, extreme	Indefinite
Due to: Chronic interstitial nephritis	"
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Isadore Tuark, M.D.
M. D. or other

Address: Catonsville-28, Md. Date signed: 9-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73d)

07763

CERTIFICATE OF DEATH

Reg. Dist. No. 4 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:
306 Mace Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Mace Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: CATHERINE M. FRIEDEL

3. (b) Social Security Number: **

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: John C. Friedel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 16, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
74	11	19		

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Conrad Krause
13. Birthplace: Germany

MOTHER
14. Maiden name: Francis ----
15. Birthplace: Germany

16. Informant: Mr. John C. Friedel
Address: 306 Mace Ave., Essex

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: Aug. 8, 1946
(month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: Balto., Md.

18. Funeral director: Loveless Funeral Home

Address: 7401 Belair Road

19. Aug 6 19 46
(Date received by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5th, 1946, at 12:25A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1946 to Aug 5 1946 and that I last saw h[illegible]ive on Aug 3 1946

Immediate cause of death	DURATION
Pulmonary Edema	
Due to: Cardiac Failure	
Due to: Arteriosclerotic Heart Disease	
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry Musnicki
M. D. or other

Address: 417½ Eastern A. Date signed: Aug 5, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07764

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Notch Cliff Md. near Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Notch Cliff near Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sister Mary Oswald Galligan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 14, 1864

8. AGE: Years	Months	Days	If less than one day
82	1	12	hrs. min.

9. Birthplace: Canton, Mass

(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Matthew Galligan

13. Birthplace: Ireland

MOTHER 14. Maiden name: Margaret Mc Keon

15. Birthplace: Boston, Mass

16. Informant: Sr. Mary Clara

Address: Notch Cliff

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5 '46 (month) (day) (year)

Cemetery or crematory: Notch Cliff

Location: Glen Cemetery

18. Funeral director: Geo. M. Fritz & Son

Address: 864 W. Pratt St.

19. 8/4/46 (Date rec'd by registrar) 19 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 19 46, at 1.57 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 19 32, to Aug 2 19 46 and that I last saw h.. alive on July 31 '46 19

Immediate cause of death	DURATION
Carcinoma of breast	18 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

07765

Reg. Dist. No. 40

1. PLACE OF DEATH:

County Baltimore

City or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, Institution, or street address where death occurred:
Belair Rd. & Halbert Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Glenarm
(If outside city or town limits, write RURAL and give nearest town)

Street No. Belair Road & Halbert Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME GEORGE W. GALLOWAY

3.(b) Social Security Number ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Effie M. Galloway

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27th, 1861

8. AGE: Years	Months	Days	If less than one day
85	3	8	hrs. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual occupation Foreman

11. Industry or business B. & O. RR

FATHER 12. Name Jesse F. Galloway

13. Birthplace Balto., Md.

MOTHER 14. Maiden name Sarah A. E. Ledley

15. Birthplace Balto., Md.

16. Informant Mrs. G. W. Galloway

Address Belair Rd. & Halbert Ave.

17. burial Date thereof Aug. 8, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Balto., Md.

18. Funeral director Lasourland Funeral Home

Address 7401 Belair Road

19. August 6 1946 Hayward B. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th, 1946, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1945 to May 5 1946 and that I last saw him alive on May 4 1946

Immediate cause of death	DURATION
Acute pulmonary edema	2 days
Due to Chronic myocardial disease	5 yrs
Due to	
Other conditions Cerebral hemorrhage	2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A Lee Kelcher md
M. D. or other

Address 4114 Northern Parkway Date signed 8/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9320)

07765 P

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:

County Baltimore (B)

City or town Brooklynwood - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Brooklynwood.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Valley Road.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hermina A. Garcis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2. 1877

8. AGE: Years	Months	Days	If less than one day
69	2	12	hrs. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER 12. Name John Garcis

13. Birthplace Germany

MOTHER 14. Maiden name Sophie Schreiber

15. Birthplace Germany

16. Informant Mrs. W. C. Steen

Address 5005 Grandon Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17 1946 (month) (day) (year)

Cemetery or crematory Western

Location Baltimore Md

18. Funeral director Ulman Funeral Home

Address 2708 Reisterstown Rd

19. 8/16 1946 (Date rec'd by registrar) R. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946, at 10 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1938, to August 14 1946 and that I last saw h alive on August 14 1946

Immediate cause of death	DURATION
Cerebro-vascular Hemorrhage	10 min.
Due to Hypertensive cardio-vascular disease.	
Due to	
Other conditions Bronchiectasis.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis B. Garcis M.D.
M. D. or other

Address Hughesville, Md. Date signed 8-14-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07767 Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mos. 2 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hosp.
How long in hospital or institution? 8 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 720 E. 23rd St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie K. Garmer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Daniel A. Garmer
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	9	18	...hrs. ...min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: William Selters
13. Birthplace: Germany
MOTHER 14. Maiden name: Dorothy (Last name unknown)
15. Birthplace: Germany
16. Informant: Hospital Records
Address: Catonsville 28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/3/46 (month) (day) (year)
Cemetery or crematory: Baltimore Cem., North ave.
Location: Baltimore, Md.
18. Funeral director: Tilhon & Son
Address: 1217 E. Fort Ave.
19. 8/31/46 (Date received by registrar) A.W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29 1946, at 6:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27 1945, to August 29 1946
and that I last saw her alive on Aug. 29 1946

	DURATION
Immediate cause of death: Cerebral Vascular Accident	3 hrs.
Due to: Cerebral Arteriosclerosis	Indef.
Due to:	
Other conditions: Colloid Goitre	Indef.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Andrew Juerk, M.D. (M. D. or other)
Address: Spring Grove State Hosp. Catonsville 28, Md. Date signed: 8-29-46

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

P 07768

Reg. Dist. No. 4-2

1. PLACE OF DEATH:
County Baltimore
City or town Lansdowne, 2. T. Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months.
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Lansdowne, 2. T. Md
(If outside city or town limits write RURAL and give nearest town)
Street No. 111 La Vernestre
(If rural, give LOCATION)
2.(a) If veteran, name war None.

3.(a) FULL NAME Gerholt - Ann Edith

3.(b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed.

6.(b) Name of husband or wife John Gerholt.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July - 31 - 1886

8. AGE: Years 60 | Months 0 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace ~~[illegible]~~ Ann. Co. Md.
(Town, county, and state)

10. Usual occupation House wife.

11. Industry or business At home.

FATHER 12. Name Joseph Richardson.
13. Birthplace Md.

MOTHER 14. Maiden name Edith Tongue.
15. Birthplace Md.

16. Informant Mrs. Frank J. Carter.
Address 111 Laverne Ave.

17. Burial. Date thereof Aug. 7th. 1946.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory London Park Cemetery.
Location Baltimore, Md.

18. Funeral director Charles J. Schwabe.
Address 505 N. Monroe St.

19. 8/6 1946 R. W. Hedrick Deg
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5th 1946, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 st 1946, to Aug. 5th 1946
and that I last saw h.. alive on August 5th 1946

Immediate cause of death	DURATION
Acute Coronitis	
Heart failure	
Due to Hypertension	
Due to Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE W. A. Spitznagle M. D. or other
Address Lansdowne, 2. T. Md Date signed 8/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-2)

CERTIFICATE OF DEATH

07769 38
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Ruxton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Howard

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town ~~Baltimore~~ Ruxton
(If outside city or town limits, write RURAL and give nearest town)
Street No. Maywood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julia Estella Gill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	widow

6.(b) Name of husband or wife Thomas Ellsworth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1875

8. AGE:

Years	Months	Days	If less than one day
70	8	17	..... hrs. ..... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Garrett Howard
13. Birthplace Md.
MOTHER 14. Maiden name Mary Akehurst
15. Birthplace Md.
16. Informant Mrs. Wm. C. Gill
Address Maywood Ave. Ruxton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29, 1946 (month) (day) (year)
Cemetery or crematory Stone Chapel Cemy.
Location Pikesville, Md.
18. Funeral director John O. Mitchell & Sons Inc.
Address 1990 Eutaw St. Balto. Md.
19. 8/28/46 (Date rec'd by registrar) Wm. Fedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1946, at 8.36 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1934 to Aug. 27 1946
and that I last saw h.. alive on August 26 1946
Immediate cause of death

	DURATION
Heart disease, Chronic myocarditis, decompensated	12 yrs
Due to Heart disease, valvular, mitral	12 yrs +
Due to Cerebral Hemorrhage, right	1934
Other conditions Hypertension with arteriosclerosis	12 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin C. Hudson M.D.
M. D. or other
Address Towson Md. Date signed 8/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07770

CERTIFICATE OF DEATH

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Maryland

How long in hospital or Institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wash.

City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Suter Alley
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

RICHARD LEWIS GILMORE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married -- Sep.

6.(b) Name of husband or wife: Rosa Belle Gilmore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 11-11-1894

8. AGE: Years	Months	Days	If less than one day
51	9	8	..... hrs. ..... min.

9. Birthplace: Charlottsville, Va.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-21-46 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Hagerstown Md.

18. Funeral director: Wm H Downey

Address: 291 Frederick St Hagerstown

19. Aug 21 1946 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 1946 at 8:43 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 17, 1946 to August 19, 1946 and that I last saw him alive on August 19, 1946

Immediate cause of death	DURATION
Disease of the Heart	5
Hypertensive & Coronary Arterio-	Months
xxx sclerosis, Cardiac enlargement,	
Myocardial Insufficiency	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIRECTOR

Address: V.A. Ft. Howard, Md. Date signed 8-19-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of age is shown on G 107 9/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07771

Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto.
City or town Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Chase Md.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Chase Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph L. Grabowski

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Anna M (nee Machowiak)
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 18 - 1865

8. AGE: Years	Months	Days	If less than one day
80 8+			hrs. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name "
15. Birthplace "

16. Informant Michael L. Grabowski (Son)
Address Chase Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/28/46 (month) (day) (year)
Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd.
18. Funeral director John G Connelly
Address 418 Eastern Ave. Essex 21 Md.

19. Aug 29, 1946 (Date rec'd by registrar) John G. Connelly, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 25 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946, to Aug 25 1946
and that I last saw him alive on Aug 25 1946

Immediate cause of death Coronary Thrombosis — DURATION: Sudden
Due to Arteriosclerosis
Cardio-Vascular disease
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Geo. M. Baumgardner, M. D. or other
Address Balto 6 Md Date signed 9-26-46

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

CERTIFICATE OF DEATH

67772 C X

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Pt.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Sparrows Pt.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Wire Mill Rd

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME James Green

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	

6.(b) Name of husband or wife Maude

6.(c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Nov. 14-1901

8. AGE:

Years	Months	Days	If less than one day
44	9	12	.....hrs. .....min.

9. Birthplace Va.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name John Green

13. Birthplace Va

MOTHER 14. Maiden name Mary Kenny

15. Birthplace Va

16. Informant John W. Green

Address 6 Fleming Drive Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30-46 (month) (day) (year)

Cemetery or crematory Mt. Zion M.E.

Location Balto Co

18. Funeral director Samuel W. Chase & Son

Address 639 N. Bulmer St. - Balto.

19. 8/29/46 (Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1946, at 10 20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .....19....., to .....19.....

and that I last saw h.....alive on .....19.....

Immediate cause of death	DURATION
1. Compound fracture Skull	
& Complete Laceration of Lung	
Due to fall	
2. Traumatic Amputation Left Arm	
Due to.....	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

.....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide UNDETERMINED Date of 8-26-46

Where did injury occur? Nr. Sp. Pt. (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) R.R. TRACKS

Means of injury STRUCK OVER BY ENGINE & TRAIN (6 CARS) Injured at work? No

23. SIGNATURE Wm. D. Davis M.D.

Address Dundalk, Md. Date signed 8-27-46

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07773 40 Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto.
City or town Sweetair
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md. County Balto -
City or town Sweetair
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wheeler Coolige Greer

3.(b) Social Security Number

4. Sex: M. | 5. Color or race: W. | 6.(a) Single, married, widowed, or divorced: —

6.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1946

8. AGE: Years | Months: 0 | Days | If less than one day: 2 hrs. 30 min.

9. Birthplace: Sweetair Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Taylor H. Green
13. Birthplace Virginia

MOTHER 14. Maiden name Violet Gwynn
15. Birthplace Virginia

16. Informant Taylor H Green
Address Topaz Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 3-1946 (month) (day) (year)

Cemetery or crematory Fork M. E. Cem
Location Fork Md.

18. Funeral director Clarence E. Luther
Address Fork Md.

19. Aug 2 1946 (Date rec'd by registrar) C. E. Luther Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1946, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1 1946 to 1946
and that I last saw h alive on August 1, 1946

Immediate cause of death	DURATION
Prematurity	3 hrs.
Due to (7 Mos.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D.
M. D. or other
Address Fork, Md. Date signed 8/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Diat. No. 6774

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Opitz Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 514 S. Gilmor St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Joseph B. Griffith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose D. Griffith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1881

8. AGE: Years	Months	Days	If less than one day
64	8	5	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:
FATHER 12. Name: Wm. H. Griffith
13. Birthplace: Md.
MOTHER 14. Maiden name: Jeannie Brooks
15. Birthplace: Md.
16. Informant: Mrs. Rose Griffith
Address: 514 S. Gilmor St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23/46. (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: 2930 Frederick Rd.
18. Funeral director: Harry H. Opitz
Address: 4101 Edmondson Ave.
19. 8-22-1946 (Date rec'd by registrar) Harry H. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 20/46. 19..... at 6 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 16 1946 to Aug 20 1946 and that I last saw h... alive on Aug 19 1946

Immediate cause of death	DURATION
Uremic Coma Arteriosclerosis	6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or coroner
Address: [address] Date signed: 8/24

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93-1) Reg. Dist. No. 43

CERTIFICATE OF DEATH

07775

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 1326 Spring AVE.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Raspeburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Spring Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME Caroline Haas

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1/1866

8. AGE: Years 80 | Months 4 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER
12. Name Martin Haas
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Lillian Huth
(b) Address 1326 Spring Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 24 46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler, Inc
(b) Address 403 S. Wolfe St. Balto.

19 (a) 8/22/46 (Date rec'd by registrar) (b) A. W. Redmond Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 20 1946 at 11 30 PM. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Aug 20 1946, and that I last saw her alive on Aug 20 1946.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardiac vascular disease	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D. or other
Address Balto 6 Md Date signed 8-20-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-6

CERTIFICATE OF DEATH

P

67776 X38

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Towson 4, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since July 23, 1946

Hospital, Institution, or street address where death occurred: Eudowood Sanatorium, Towson 4, Md.

How long in hospital or institution? Since July 23, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) Allegany

State: Maryland County: Washington

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 411 Columbia (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME George Hagamier

3.(b) Social Security Number 214-12-2493

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	married

8.(b) Name of husband or wife: Emma Hagamier

8.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): October 7, 1900

8. AGE: Years: 45 | Months: 10 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: Farmer & Laborer

11. Industry or business:

FATHER 12. Name: Lewis Hagamier

FATHER 13. Birthplace: Cumberland Md

MOTHER 14. Maiden name: Susan Beal

MOTHER 15. Birthplace: Cumberland Md

16. Informant: Personal History- Hospital Records

Address: Eudowood Sanatorium, Towson 4, Md.

17. Burial (Burial, cremation, or Removal. Which?) Date thereof 8/21/46 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie Md

18. Funeral director: Wilson Cook Inc

Address: 1247 York Rd Towson 4

19. 8/20/46 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1946 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1946, to August 19 1946 and that I last saw h.. alive on August 15 1946

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 4 Mos.

Due to: — DURATION: Since 1932

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W G Bridges M. D. or other

Address: Towson 4, Maryland Date signed: 8-19-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (931)

CERTIFICATE OF DEATH

07777

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: Chatsworth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah C. Hampton

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

9.(b) Name of husband or wife: Fremont W. Hampton
9.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 27, 1870

8. AGE: Years	Months	Days	If less than one day
76	6	15	hrs. min.

9. Birthplace: Balto. Co.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John S. Morris
13. Birthplace: Balto. Co.

MOTHER
14. Maiden name: Elizabeth Cooper
15. Birthplace: Balto. Co.

16. Informant: Fremont W. Hampton
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 13, 1946 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Balto. Co.
19. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. Aug 13 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/11/46 19.... at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/46 19.... to 8/11/46 19....
and that I last saw her alive on 8/10/46 19....

	DURATION
Immediate cause of death: Myocarditis. Chronic	2 yrs
Due to: decompensatio cordis	
Due to: arteriosclerosis	
Due to: hypertrophic arthritis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lawrence G. Sahd M. D. or other
Address: Reisterstown Md. Date signed: 8/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94-a

CERTIFICATE OF DEATH

07778

Reg. Dist. No. 38

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 Years
Hospital, institution, or street address where death occurred: 604 Central Avenue
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 604 Central Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3. (a) FULL NAME Joseph T. Hanley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---- years

7. Birth data of deceased (mo., day, yr.): August 25, 1900

8. AGE: Years	Months	Days	If less than one day
45	11	29	-- hrs. -- min.

9. Birthplace: Lutherville, Md. (Town, county, and state)
10. Usual occupation: Asst. Cashier
11. Industry or business: 2d National Bk. of Towson

FATHER
12. Name: Richard Hanley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Padian
15. Birthplace: Maryland

16. Informant: Richard F. S. Hanley
Address: 604 Central Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/26/46 (month) (day) (year)
Cemetery or crematory: Monte Marie
Location: Towson, Md.
18. Funeral director: H. W. Mears and Son
Address: 805 N. Calvert Street

19. Aug 25 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1946, at about 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Charles F. O'Donnell M. D. or other
Address: 730 York Rd. Date signed: 8 Sept 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

07779

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 yrs.
Hospital, Institution, or street address where death occurred: at home
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 409 Allegheny Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME Minnie Elizabeth Roman Standley

3.(b) Social Security Number none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Richard J Standley
6.(c) If alive, give age ... yrs
7. Birth date of deceased (mo., day, yr.): June 25 1857
8. AGE: Years 89 Months 1 Days 23 If less than one day ... hrs. ... min.
8. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none
FATHER 12. Name: Joseph Roman
13. Birthplace: Germany
MOTHER 14. Maiden name: Teirthid — ?
15. Birthplace: Germany
16. Informant: Mrs Edith L H Ball (daughter)
Address: 409 allegheny - Towson
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug. 20-46 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Balto Md.
18. Funeral director: Stewart & Mcgrath Co.
Address: 108 W North Ave.
19. Aug 19 1946 (Date rec'd by registrar) A. K. Hedrick P.C. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1946 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 44 to Aug 17 1946
and that I last saw h.w. alive on Aug 16 1946
Immediate cause of death: Arteriosclerosis — DURATION
Hypertension
Chronic Interstitial Nephritis
Due to: ...
Due to: ...
Other conditions: Hypertensive Coronary Artery Dis
(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: H. L. Dooley M. D. or other
Address: 817 Medical Arts Bldg Date signed: Aug 19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57-a)

CERTIFICATE OF DEATH

07780

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore County
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Essex Farms
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ********

3.(a) FULL NAME: William Byron Harrington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife: **********
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 28, 1946

8. AGE: Years	Months	Days	If less than one day
	3	23	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: Edward Stanley Harrington
13. Birthplace: Wilmington, Del.

MOTHER
14. Maiden name: Gertrude Downey
15. Birthplace: Chestertown, Maryland

16. Informant: Mrs. Gertrude D. Harrington
Address: Essex Farms, Balto., Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 23/46 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Maryland

18. Funeral director: H. W. Mears & Son
Address: 805 N. Calvert St., Balto., Md.

19. 8/22 (Date rec'd by registrar) 19 46 D. V. Acker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 21st 19 46 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 46, to 19 and that I last saw h. alive on July 19 46

	DURATION
Immediate cause of death: hydrocephalus	Instt
Due to:	
Due to:	
Other conditions: Spina bifida	Instt

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jack J. Singer M D
M. D. or other
Address: 506 E. North Ave Date signed: 8/22/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-M)

CERTIFICATE OF DEATH

07781

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6600 Greenock Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6600 Greenock Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Laurence R Hartman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Ida Hartman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 27 1907

8. AGE: Years: 38 | Months: 7 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: aeroplane
11. Industry or business: Inspector
FATHER 12. Name: Wm J Hartman
13. Birthplace: Md
MOTHER 14. Maiden name: not available
15. Birthplace: Md
16. Informant: Mrs Ida Hartman
Address: 6600 Greenock Drive
17. (Burial, cremation, or removal. Which?) Burial Date thereof 8-12-46 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Baltimore Md
18. Funeral director: Geo A Fackler
Address: Catonsville Md
19. 8-12 1946 (Date rec'd by registrar) Harry Jay Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1946, at about 4 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carbon Monoxide Poison	
Due to: from automobile	
Due to: Suicide	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of Aug 8 46
Where did injury occur? Catonsville Baltimore (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Garage at home
Means of injury: Carbon monoxide gas Injured at work? no

23. SIGNATURE: Geo W. Kiefer Dep Med Exam Balto Co. M. D. or other
Address: 1010 Leadenhall Date signed: Aug 9 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

67782

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5346 St Charles Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James H Heaps

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed.

6.(b) Name of husband or wife Belle Heaps
6.(c) If ative, give age years
7. Birth date of deceased (mo., day, yr.) Sept 21 1862

8. AGE: Years	Months	Days	If less than one day
83	10	29	hrs. min.

9. Birthplace Harford Co Md.
(Town, county, and state)
10. Usual occupation Laborer.
11. Industry or business
FATHER 12. Name Henry Heaps
13. Birthplace Harford Co Md.
MOTHER 14. Maiden name Mary Ann Murphy
15. Birthplace Harford Co. Md.
16. Informant Mrs Geo Callender
Address Bond & Central ave Reisterstown Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof Aug 23 1946 (month) (day) (year)
Cemetery or crematory Shofe Ridge Cem.
Location Delta Pa
18. Funeral director Hubert P. Hakens.
Address Delta, Pa.
19. 8-20 1946 Mary B. Elins. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 august 1946, at 9 45 p M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 august 1946, to 20 aug 1946
and that I last saw him alive on 14 august 1946

Immediate cause of death	DURATION
arteriosclerosis	>
arteriosclerotic Heart disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. F. Ermshar M.D. M. D. or other
Address 22 Hanover Rd. Reisterstown Md. Date signed 20 aug 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63-H)

CERTIFICATE OF DEATH

07783

Reg. Diat. No. 92

1. PLACE OF DEATH:
County: Randallstown
City or town: Balto.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 72 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Liberty Rd.
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: Randallstown
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Miss Lena B Helwig

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	

6.(b) Name of husband or wife: Philip Helwig
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 25 - 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	9	23		

9. Birthplace: Randallstown · Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Frederick Helwig
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Clay
15. Birthplace: Balto. Co. Maryland

16. Informant: Anna B. Morgan
Address: 5503 Magnolia Ave. Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 16. 46 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Randallstown · Md.

18. Funeral director: Frank H. Newell
Address: Pikesville · Maryland

19. 8-16-1946 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1946, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1946, to Aug 13 1946, and that I last saw her alive on Aug 13 1946

Immediate cause of death	DURATION
Gas Poisoning (Suicide)	4 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8-13-'46
Where did injury occur? Randallstown (City or town) Balto. (County) Md. (State)
Injured at home, farm, industry, public place (where?): Home.
Means of injury: Gas Poisoning Injured at work? No.

23. SIGNATURE: D. D. Caples, M.D. (M. D. or other) Med. Exam.
Address: Reisterstown, Md. Date signed: 8-13-'46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-7)

CERTIFICATE OF DEATH

C7784 32
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Randallstown Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 Yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Balto.
City or town Randallstown Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Offutt Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary E. Helwig

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23 - 1904

8. AGE: Years	Months	Days	If less than one day hrs.	min.
42	2	24		

9. Birthplace Randallstown, Maryland
(Town, county, and stete)
10. Usual occupation Housework
11. Industry or business
FATHER 12. Name Phillip Hellwig
13. Birthplace Germany
MOTHER 14. Maiden name Lena B. Hellwig
15. Birthplace Randallstown Md.
16. Informaot Frank M. Tillett
Address Randallstown, Maryland
17. Burial (Burial, cremetion, or removel. Which?) Date thereof Aug. 16, 46 (month) (day) (year)
Cemetery or crematory Mt. Olivet
Location Randallstown, Maryland
18. Funeral director Frank H. Newell
Address Pikesville, Maryland
19. 8-16-46 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946 at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 1946 to Aug 13 1946 and that I last saw her alive on Aug 13 1946

Immediate cause of death	DURATION
Gas Poisoning (Suicide)	4 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Suicide Date of Aug 13 '46
Where did injury occur? Randallstown, Balto. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of Injury Gas Poisoning. Injured at work? No.

23. SIGNATURE D. D. Caples M.D. Med. Exam.
M. D. or other
Address Reisterstown, Md. Date signed 8-13-'46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P 07785

Reg. Dist. No. 114

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft.Howard, Md.

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 116 N. Gay St.

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: HETTCHE, William F. (alias John Smith)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Anna Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 6, 1904

8. AGE: Years	Months	Days	If less than one day
41	11	12	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business:

FATHER — 12. Name: unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: Amelia Saunders

15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft.Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-22-46 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: Oder Funeral Home Inc.

Address: 4644 York Rd., Balto., Md.

19. 8/22 1946 (Date rec'd by registrar) D.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1946, at 2:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 1946, to August 18 1946 and that I last saw him alive on August 18 1946

Immediate cause of death: Subacute atrophy of liver

Due to: Chronic Pancreatitis

DURATION: 1 Month

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison ROBERT M. CULLISON, M.D. CLIN.DIR. M. D. or other

Address: Ft.Howard,Md. Date signed: 8-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

07786 39

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Cockeysville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Falls Rd - (Rural
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Cockeysville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Falls Rd. (Rural)
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: George Casper Hoffman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mollie Miller Hoffman
6(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): July 10 1865

8. AGE: Years	Months	Days	If less than one day
81	0	23	hrs. min.

9. Birthplace: Cockeysville Balto Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer -
11. Industry or business:
FATHER 12. Name: Casper Hoffman
13. Birthplace: Germany
MOTHER 14. Maiden name: unknown
15. Birthplace: Germany -
16. Informant: Mrs Geo. Hoffman
Address: Cockeysville Md -
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5 1946 (month) (day) (year)
Cemetery or crematory: Grace Church
Location: Chestnut Ridge, Balto Co, Md
18. Funeral director: Landon M. Brooks
Address: Sparks, Md.
19. Aug. 3 (Date rec'd by registrar) 46 Wilmer C. Ensor (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1946, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1944, to Aug 2 1946, and that I last saw him alive on Aug 1 1946.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Yrs
Due to Arterio Sclerosis -	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Dt operations:
Dt autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D.
M. D. or other
Address: Cockeysville Md Date signed 8/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07787 44
Reg. Diat. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 Right Elevator Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3. (a) FULL NAME
OLIE HOLLANDER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Deceased
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	22	..... hrs. ..... min.

9. Birthplace: St. Louis, Mo. (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Joseph W. Hollander (dead)
13. Birthplace: Germany

MOTHER
14. Maiden name: Mattie Reed (dead)
15. Birthplace: unknown

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. What?) Date thereof 8-9-46 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Fredericksburg
18. Funeral director: Oder Funeral Home, Inc.
Address: 4644 york Rd. Balto. Md.

19. 8/9 1946 A W Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 7 1946 at 2:18 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20, 1946, to August 7 1946
and that I last saw him alive on August 7 1946

Immediate cause of death	DURATION
CARCINOMA OF PROSTATE	3 Years
Due to	
Due to	
Other conditions: Peritoneal Metastasis	
Obstruction Ureter, Pyelonephritis	Unknown
Uremia (Include pregnancy within 3 months of death)	

Major findings of operations: ..... Date of op. .....
Autopsy results: Same as Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert M. Cullison ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: Ft. Howard, Maryland Date signed: 8-7-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

CERTIFICATE OF DEATH

07788 B

Reg. Dist. No. 39

1. PLACE OF DEATH:
County Baltimore
City or town Sparks, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of motber)
State Md. County Baltimore
City or town Sparks
(If outside city or town limits, write RURAL end give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME RUTH HORNER

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife none
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 30, 1911

8. AGE: Years	Months	Days	If less than one day
35	2	3	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Michael T. Horner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden name Loula G. Kraft
15. Birthplace Balto. County Md.

16. Informant Mr. John Horner
Address Phoenix Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/46 (month) (day) (year)
Cemetery or crematory Greenmount
Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC.
Address North & Pa Aves. Balto. Md.

19. 8/5 46 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1946, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1938, to Aug 3 1946
and that I last saw ... alive on Aug 2 1946

	DURATION
Immediate cause of death Carcinomatosis generalized metastasis-adeno-Carcinoma related ovarian origin	2 yrs +
Due to	
Due to	
Other conditions Anemia secondary	1 yr

(Include pregnancy within 3 months of death)

Major findings of operations Exploratory Laparotomy-adeno-carcinoma, metastatic. Date of op. June 1946
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Rollin E. Hudson M.D.
M. D. or other
Address Towson 4 Md Date signed 8/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

02789

1. PLACE OF DEATH

County Baltimore — 22. Registration Dist. No. 44

Village or City Sparrows Point. No. 2603 Sparrows Pt. Rd. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Samuel Marid JEFFERIS If U. S. Veteran, specify WAR NONE

(a) Residence: No. as in # 1. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married.

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Frieda Jefferis

6. DATE OF BIRTH (month, day, and yeer) Nov. 11. 1906.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39.	9	8	

OCCUPATION

8. Trade, profession, or perticular kind of work done, es SPINNER, SAWYER, BDOKKEEPER, etc. Steel worker.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Steel mill.

10. Date deceesed lest worked et this occupation (month end year) July. 1943

11. Total time (years) spent in this occupetion 18yr.

12. BIRTHPLACE (city or town) Steubenville. (State or country) Ohio

FATHER

13. NAME Albion Jefferis

14. BIRTHPLACE (city or town) Richardson (State or country)

MOTHER

15. MAIDEN NAME Cora Bell.

16. BIRTHPLACE (city or town) Unknown (State or country)

17. INFORMANT Mrs. Margaret F. Jefferis (Address) 2603 Sp. Pt. Rd

18. BURIAL, CREMATION, OR REMOVAL Place Oak Lawn Date Aug. 22, 1946

19. UNDERTAKER John G. Connelly (Address) 418 Eastern Ave. Essex

20. FILED Aug. 20, 1946 John G. Connelly Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August. 20., 1946. (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from July., 1943, to Aug. 20, 1946.

I last saw h. in alive on Aug. 19, 1946; death is said to have occurred on the date stated above, at 2:20A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importence were as follows:

	Date of onset
Pulmonary Tuberculosis	3 1/2 yr
Dther **Contributory Causes** of importance:	

Name of operation Date of

What test confirmed diagnosis? Was there en autopsy? No

23. If death wes due to external causes (VIDLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, In HDME, or In PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way releted to occupation of deceased?

If so, specify

(Signed) Louis H. Talley M. D.

(Address) 6908 North Pt. Rd

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore (Request No. 7) S. No. 19- md

Essex — 19 - md

V. S. No. 1

N. B.—WRITE MAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

07790

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore County
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred: Vets. Adm. Fort Howard, Md.
How long in hospital or institution? 30 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1619 Covington St. Balto. Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1.

3.(a) FULL NAME: Arthur E. Jones

3.(b) Social Security Number: 216-10-1123

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Rose V. Jones

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11 mo. 29 da. 1895

8. AGE: Years 50 Months 9 Days 2 If less than one day: hrs. min.

9. Birthplace: Towson, Maryland
(Town, county, and state)

10. Usual occupation: Collector

11. Industry or business:

FATHER
12. Name: Leonard Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Hines
15. Birthplace: Unknown

16. Informant: Clinical Records
Address: Vets. Adm. Fort Howard, Md.

17. Burial, cremation, or removal: Burial (Which?) Date thereof: Sept 4 1946 (month) (day) (year)
Cemetery or crematory: Maryland Memorial
Location: Balto Co.
18. Funeral director: A. Howard Evans
Address: 1400 N. Charles St

19. (Date rec'd by registrar) 9-3 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 19 46, at 6:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 19 46, to Aug. 31 19 46
and that I last saw him alive on August 31, 19 46

Immediate cause of death: Fibrosarcoma of pelvis — DURATION: 6 months plus

Due to:

Due to:

Other conditions: Lymph Edema, left leg, left hip, left buttocks and left side of lower abdomen.
(Pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: n.a. Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. Cullison M. D. Clin. Dir. M. D. or other
Address: Vets. Hosp. Ft. Howard Md. Date signed:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

07791

Reg. Diat. No. 33 –

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Baltimore
City or town Maryland Line,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Maryland Line
(If outside city or town limits, write RURAL and give nearest town)
Street No. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Sarah Thelma Jones.

3.(b) Social Security Number 180-03-8717.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married.

6.(b) Name of husband or wife Nolan E Jones.
6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) January 3, 1911.

8. AGE: Years 35 | Months 8 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace Maryland Line, Md.
(Town, county, and state)

10. Usual occupation Operator

11. Industry or business Sewing factory.

FATHER 12. Name Murray Sampson

13. Birthplace Md. Line, Md.

MOTHER 14. Maiden name Mary Carman.

15. Birthplace N. Hopewell Twnp. York Co. Penna.

16. Informant Nolan E. Jones.

Address Maryland Line, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 29, 1946 (month) (day) (year)

Cemetery or crematory New Freedom Cemetery

Location New Freedom, Penna.

18. Funeral director Jacob Hartenstein

Address New Freedom Pa

19. Aug 28 1946 (Date received by registrar) Charles L Fuller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1946, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946, to Aug 27, 1946 and that I last saw h.e alive on Aug 26 1946

Immediate cause of death	DURATION
Squamous sarcoma of mediastinum	3/4 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul D. Shuck, M.D.
M. D. or other

Address Kreutzburg, Pa Date signed 8/27/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07792 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. 122 Rosemont Ave (If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Thomas Harvey Jones Sr

3. (b) Social Security Number: 212-07-2356A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary Ellen

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): April 23 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	3	14		

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Ass't Treasurer

11. Industry or business: Stewart + Co.

MOTHER FATHER

12. Name: Howard Jones

13. Birthplace: Baltimore Md

14. Maiden name: Mary E Starkey

15. Birthplace: Baltimore Md

16. Informant: Mrs Thomas Jones

Address: 122 Rosemont Ave - Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 10 46 (month) (day) (year)

Cemetery or crematory: Mon Cath

Location: Baltimore Md

18. Funeral director: Wm Bolt Jno

Address: Baltimore Md

19. 8/8 46 H.W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 7 1946, at 8.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1946, to Aug 7 1946

and that I last saw h... alive on Aug 6 1946

Immediate cause of death	DURATION
Bronchogenic Carcinoma	6 Mon.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph E Towers M. D. or other

Address: Catonsville Date signed: 8-7

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

07793

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Eleven days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? Eleven days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: .....

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 East Hamburg St

(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: Reuben ~~Rubin~~ W. Kimball

3.(b) Social Security Number: 705-05-6347

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ~~Amelia Hagner~~ Amelia Rohmer nee (Deceased)

6.(c) If alive, give age ~~77~~ years

7. Birth date of deceased (mo., day, yr.): October 1, 1865

8. AGE: Years: 80 Months: 10 Days: ~~27~~ If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore, Md

10. Usual occupation: Retired ~~Clerk~~ Stationary Fireman

11. Industry or business: B & O Railroad - Transportation

FATHER

12. Name: George S. Kimball

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Mary Baker

15. Birthplace: Baltimore, Md.

16. Informant: Hospital records, Spring Grove State Hospital, Catonsville, 28, Md.

Address: .....

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 26 1946 (month) (day) (year)

Cemetery or crematory: Dedarfield Cem.

Location: Anne Arundel Co.

18. Funeral director: C. Howard Evans

Address: 1400 E. Charles St. Balto 30, Md

19. 8/26/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22, 1946 19..... at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1946 19..... to August 22, 19 46 and that I last saw him alive on August 22, 1946 19.....

Immediate cause of death	DURATION
Terminal pneumonia	48 hrs
Due to: Chronic arteriosclerotic cardio-vascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 8/22/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1860)

Registered No. 42

07794

1. PLACE OF DEATH: County
(a) Baltimore City, Maryland
(b) Street address 444 N Wilkens ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 444 Wilkens ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arabella Lafferty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Louis N. Lafferty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1865

8. AGE: Years 81 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER 12. Name William McKnew

13. Birthplace Baltimore

MOTHER 14. Maiden Name Sarah ?

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marjorie Fathroe

(b) Address 444 N Wilkens ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-3-46 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Frederick A Cole

(b) Address 1200 W Lombard St

19 (a) Sept 3 46 (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1946 at 8-10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1946, to Aug 30 1946, and that I last saw h[illegible] alive on 29 Aug 1946

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Accidental fall. cause

Due to

Other Conditions Fractured Right Hip — 2½ Months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 5th 1946 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? in her home (Specify type of place) While at work?
(e) Means of injury Racusin

23. Signature Nathan Rennin M. D.

Address 206 S. Gilmor St. Date signed 9-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07795

CERTIFICATE OF DEATH

Reg. Diat. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 13 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Cecil

City or town: Warwick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: None

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: GEORGE W. LAMBERT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	M-Separated

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 22, 1888

8. AGE: Years	Months	Days	If less than one day
58	1	3	..... hrs. ..... min.

9. Birthplace: Warwick, Maryland (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business:

FATHER — 12. Name: Theodore Lambert

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Laura Field

15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29, 1946 (month) (day) (year)

Cemetery or crematory: ~~Fefasfa~~, Md., Annapolis

Location: Natl Cem

18. Funeral director: Austin Caulk

Address: 827 Pine St., Wil. Del.

19. Aug 30 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1946 at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12, 1946, to August 25, 1946

and that I last saw h..im alive on August 25, 1946

Immediate cause of death	DURATION
Coronary Occlusion, acute	Sudden
Due to Heart disease - Coronary arterio-	
sclerosis; Auricular Fibrillation,	
xxx Myocardial Insufficiency.	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: R. M. Cullison, M. D. Clin. Dir. (M. D. or other)

Address: V. A. Ft. Howard, Md. Date signed: 8-25-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

P07796

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Pikesville (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Mt. Pleasant Sanatorium

Stay in hospital or inst. (yrs., or mos., or days): 3 years.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1405 E. Baltimore St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3.(a) FULL NAME: Aaron (Abraham) Levin.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife: Cecilia Levin

6(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): ? ? 1867

8. AGE: Years: 79 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business:

FATHER — 12. Name: David Levin

FATHER — 13. Birthplace: Russia

MOTHER — 14. Maiden name: Leah ?

MOTHER — 15. Birthplace: Russia

16. Informant: Cecilia Levin (wife)

Address: 2703 Old Springhouse Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-15-46 (month) (day) (year)

Cemetery or crematory: Woodlawn Circle

Location: Nehrew Mt. Carmel

18. Funeral director: Jack Levin Inc

Address: 1639 E. Balto. St.

19. 8/14/46 (Date rec'd by registrar) A-W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14, 1946, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15, 1943, to August 14, 1946, and that I last saw him alive on August 14, 1946.

Immediate cause of death	DURATION
Myocardial Failure	
Due to Myocardial Insufficiency	2 weeks
Due to Pulmonary Tuberculosis	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert F. Shrier M.D. M. D. or other

Address: Pikesville, Md. Date signed: 8/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-0)

CERTIFICATE OF DEATH

07845 44
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Balto.

City or town Middlebrook
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Balto.

City or town Hamilton Ave.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3410 Hamilton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war J

3. (a) FULL NAME Jennings L. Tiller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 19 — 1922

8. AGE: Years	Months	Days	If less than one day
23	8	26	..... hrs. ..... min.

9. Birthplace Md., Allegheny Co.
(Town, county, and state)

10. Usual occupation Gas & Elec.

11. Industry or business Pipe Fitter

FATHER 12. Name Wm. J. Tiller

13. Birthplace W. Va.

MOTHER 14. Maiden name Ruby Leith

15. Birthplace W. Va.

16. Informant Mrs. Wm. J. Tiller

Address 3410 Hamilton ave.

17. Removed (Burial, cremation, or removal. Which?) Date thereof 9/18/46 (month) (day) (year)

Cemetery or crematory Upon Budge

Location W. Va.

18. Funeral director John E. Connelly

Address 418 Eastern Ave. Essex 21, Md.

19 Aug. 18 (Date rec'd by registrar) 19 46 John E. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 19 46 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured 3rd & 4th Cervical Vertebrae	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8-15-46

Where did injury occur? Back Run Md. (City or town) Balto. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Road

Means of injury Auto Accident Injured at work? No

23. SIGNATURE C. B. Davis M.D.

M. D. or other Dep. Med. Examiner Balto. Co.

Address Towson 4, Md. Date signed 8/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

07797

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 6 months, 23 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 8 years, 6 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Doncaster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Daisy Long

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 13, 1905

8. AGE:

Years	Months	Days	If less than one day
40	9	29	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Joseph Long

13. Birthplace: Maryland

MOTHER

14. Maiden name: Ada Dodd

15. Birthplace: Maryland

16. Informant: Hospital Records, Spring Grove State Hospital, Catonsville, 28, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/13/46 (month) (day) (year)

Cemetery or crematory: Montgomery Baptist Cem

Location: Montgomery Md

18. Funeral director: Blend & Myers

Address: Waldorf Md

19. 8-13- 1946 (Date rec'd by registrar) Harry W. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11, 1946 19..... at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19, 1938 19..... to August 11, 1946 19..... and that I last saw her alive on August 11, 1946 19.....

	DURATION
Immediate cause of death: Uremia	48 hours
Due to: Chronic glomerular nephritis	Indef
Due to:	
Other conditions: Post encephalitic syndrome	"
Imbecility (aquired?)	"

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 8/11/46

Henry C. A. Mead, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-ed)

CERTIFICATE OF DEATH

0P28

Reg. Diat. No. 30

1. PLACE OF DEATH: Baltimore
County.....
City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, Institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md, County Baltimore
City or town CATONSVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. INGELSIDE 1st HARFord Road
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3.(a) FULL NAME PAUL LORENZ

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	Widowed

6.(b) Name of husband or wife MARY LORENZ
6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) October 20- 1861

8. AGE: Years 84 | Months 9 | Days 13 | If less than one day .....hrs. .....min.

9. Birthplace GERMANY
(Town, county, and state)

10. Usual occupation NONE

11. Industry or business

FATHER
12. Name UNKNOWN ✓
13. Birthplace

MOTHER
14. Maiden name ✓
15. Birthplace

16. Informant ANNA M. KOONTZ
Address INGELSIDE 1st HARFORD ROAD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof August 6- 1946 (month) (day) (year)
Cemetery or crematory NEW CATHEDRAL
Location BALTO MD

18. Funeral director Roff & B. M. Walters
Address PRATT & STRICKER Sts

19. 8/5 1946 (Date rec'd by registrar) A. O. Heinrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1946, at 5-30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 August 1946, to 2 Aug 1946 and that I last saw h. l. m. alive on 1 August 1946

	DURATION
Immediate cause of death: Respiratory failure	—
Due to: Carcinoma lungs, metastasis, vocal cords	Unknown
Due to:	
Other conditions: Cerebral & probable generalized metastises	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations.....
.....Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Stephen L. Magness MD
M. D. or other
Address 752 Frederick Ave Date signed 3 Aug 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

8799 8

Reg. Diat. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Months
Hospital, institution, or street address where death occurred:
1806 Selma Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Florida County:
City or town: Miami
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4612 N. W. 15th Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Charlotte M. Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Late Warren L. Martin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1896

8. AGE: Years	Months	Days	If less than one day
49	9	6	hrs. min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William P. Muir
13. Birthplace: Penna.

MOTHER
14. Maiden name: Anna Yeager
15. Birthplace: Penna.

16. Informant: Mr. Charles M. Martin
Address: Miami, Fla.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug. 6/46. (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: 3801 Frederick Rd.
18. Funeral director: Harry A. Tuttle
Address: 4101 Edmondson Ave.
19. 8/6 1946 (Date rec'd by registrar) A. W. Helmick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 4/46 19 at 7301 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1946 to Aug 3 1946 and that I last saw h[illegible] alive on Aug 3 1946

	DURATION
Immediate cause of death: Carcinoma of Breast	18 Months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Arthur J. Davies M.D. M. D. or other
Address: 800 N 33rd St Date signed: 8-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

P 67800

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Mos.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 506 S. Bentalou Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence N. Martin

3.(b) Social Security Number: 7

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William T. Martin
6.(c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.): 12 - 1 - 1881

8. AGE: Years	Months	Days	If less than one day
65	8	11	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: Robert C. Fish
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Anna E. Wolfe
MOTHER 15. Birthplace: Maryland
16. Informant: Mr. William R. Martin
Address: 506 South Bentalou St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 16 Aug. 46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore Maryland
16. Funeral director: C. B. Wippert & Son
Address: F.B.WIPPERT & SON 1300 EUTAW PLACE. CITY
19. 8/15/46 (Date rec'd by registrar) A.W. Hebrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 August 1946, 19..., at 11:59 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 - 1946, to Aug 12 1946
and that I last saw her alive on Aug 12 1946

	DURATION
Immediate cause of death: Pulmonary Embolism	
Due to: Myocarditis	
Due to: Diabetes	
Due to: Arteriosclerosis	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert C. Fish M. D. or other
Address: 2151 Walbrook Ave Date signed: Aug 14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8

Reg. Dist. No. 07801 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Beach Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. Beach Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3. (a) FULL NAME: Margaret A. Mayberry

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Mar.

6.(b) Name of husband or wife: George W.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 1. 1882

8. AGE: Years: 64 | Months: 7 | Days: 9 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Wilhelm Gerhardt
13. Birthplace: Manchester England

MOTHER
14. Maiden name: Anna Vonhardagen
15. Birthplace: Alsace-Lorraine

16. Informant: Catherine Gill
Address: Middle River Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 8/13/46 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore Md.

18. Funeral director: Wilhelm Cook Inc.
Address: 1219 E. Fort Ave.

19. 8/12 1946 A. W. Hedrick D.R. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10 1946, at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2nd 1946 to August 10 1946 and that I last saw h alive on August 10 1946

	DURATION
Immediate cause of death: Chronic Myocarditis	2 yrs.
Due to:	
Due to:	
Other conditions: no	

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James F. White M.D.
M. D. or other
Address: 7601 Eastern Ave. Baltimore 24, Md. Date signed: 8-10-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 7802 33 Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Ward's Chapel Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3507 Plateau ave
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Elaine S. McAllister

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Calvin N. McAllister
6.(c) If alive, give age: 34 years
7. Birth date of deceased (mo., day, yr.): 8 Oct 1917

8. AGE:

Years	Months	Days	If less than one day
28	10	10	hrs. min.

9. Birthplace: Hagerstown, Md.
(Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: Bendix-Frieu
FATHER 12. Name: William F. Stauffer
FATHER 13. Birthplace: Maryland
MOTHER 14. Maidee name: anna Spielman
MOTHER 15. Birthplace: Hagerstown, Md.
16. Informant: Husband-Calvin N. McAllister
Address: 3507 Plateau ave Balto. Md
17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/30/1946 (month) (day) (year)
Cemetery or crematory: London Park
Location: Frederick ave Baltimore
18. Funeral director: E. Willis Lampeau
Address: 4570 Liberty Heights Ave, Balto
19. Aug 29 1946 (Date rec'd by registrar) Mary B. Eline: Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about 18 august 1946, at Exact time unknown
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19
Coroner Inquiry
and that I last saw h alive on 19
Immediate cause of death: Bullet wound of Skull — DURATION
Self Inflicted
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op
Autopsy results: Bullet Wounding: Right temporal region exit: left temporal region
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 18 August 1946
Where did injury occur? Ward's Chapel Rd. (City or town) Baltimore (County) Md. (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Bullet Wound Injured at work?

23. SIGNATURE: H. F. Ernshaw M.D. acting Deputy Coroner (M. D. or other)
Address: Reisterstown, Md. Date signed: 29 Aug 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

07803

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years, 2 mos., 3 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 11 yrs., 2 mos., 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Market Place (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME: John McCall

3. (b) Social Security Number:

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: -

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): October 8, 1871

8. AGE:

Years	Months	Days	If less than one day
74	10	21	... hrs. ... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ?

FATHER 12. Name: Albert McCall

13. Birthplace: Baltimore, Maryland

MOTHER 14. Maiden name: Georgina Virginia Slaughter

15. Birthplace: Baltimore, Maryland

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12, 1946 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 9-12-1946 (Date rec'd by registrar) Harry H. Miller, Deputy, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 4:55 a.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19... and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute cardiac failure	
Due to: Cardio vascular disease	
Due to: fracture right femur	
Other conditions: accident	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: about 10-30 am

Accident, suicide, or homicide: accident Date of: Aug 10. 1946

Where did injury occur? Catonsville (City or town) Balto (County) Md (State)

Injured at home, farm, industry, public place (where?) hospital

Means of injury: unknown possibly fall Injured at work? no

23. SIGNATURE: Geo. M. Kieffer, Dep. Med. Exam. Balto Co, M. D. or other

Address: 1010 Leeds Ave Date signed: Aug 29. 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

07804

Reg. Diat. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Hrs.

Hospital, Institution, or street address where death occurred:
Vets. Adm. Hospital, Ft. Howard, Md.

How long in hospital or institution? 2 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Fred.

City or town: Frederick
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Military & meade Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3. (a) FULL NAME

KENNETH H. McCLAIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ////// Josephine McClain

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): 2-11-1901

8. AGE: Years	Months	Days	If less than one day
45	5	11	..... hrs. ..... min.

9. Birthplace: New Holland, Ohio
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Clinical Records, Vets. Adm. Hosp.

Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-5-1946 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Frederick, Md.

18. Funeral director: Etchinson Funeral Home

Address: Frederick, Md.

19. 8/5 '46 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1946 at 3:59 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1946, to August 2, 1946 and that I last saw him alive on August 2, 1946

Immediate cause of death	DURATION
ACUTE TOXIC HEPATITIS,	Unknown
CAUSE UNKNOWN	
Due to	
Due to	
Other conditions: Rheumatic heart disease,	Unknown
Mitral and Aortic Endocarditis with	

(Include pregnancy within 3 months of death)

Major findings of operations: Mitral insufficiency. Congenital cystic Kidneys

Date of op.

Autopsy results: Same as Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robt M. Cullison
R.M. CULLISON, M.D., CLIN. DR. M. D. or other

Address: V.A. Ft. Howard, Md. Date signed: 8/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07805 38

1. PLACE OF DEATH:
County 803 Wellington Road
City or town Baltimore - rural - Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore - rural - Stoneleigh
(If outside city or town limits, write RURAL and give nearest town)
Street No. 803 Wellington Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Oscar Littleton McDaniel

3.(b) Social Security Number 216-03-7993

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary Dorman McDaniel
6.(c) If alive, give age 59~~58~~ years

7. Birth date of deceased (mo., day, yr.): Oct. 13, 1882

8. AGE: Years	Months	Days	If less than one day
63	10	15	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Supt. - retired
11. Industry or business: La Motte Co.

FATHER
12. Name: John McDaniel
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Adelaine Henderson
15. Birthplace: Baltimore, Maryland

16. Informant: Mrs. Mary McDaniel - widow
Address: 803 Wellington Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/30/46 (month) (day) (year)
Cemetery or crematory: Parkwood cemetery
Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.
Address: NORTH AVE. & BROADWAY

19. 8/30/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1946 at 6 A.M. approx.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19..., to ... 19...
and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Heart disease, coronary artery, with occlusion	8/28/46
Due to Heart disease, chronic myocarditis with decompensation (moderate)	5 yrs
Due to Hypertension, arteriosclerosis	Unknown
Other conditions Cerebral hemorrhage, right	Unknown 1941

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D., D.M.E. M. D. or other
Address: Towson 4 Md. Date signed 8/28/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-2

CERTIFICATE OF DEATH

Reg. Diat. No. C78064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 29 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wash

City or town: Hancock

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #1

(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3. (a) FULL NAME: DANIEL W. McFARLAND

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Eula S. McFarland

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 3-18-1897

8. AGE: Years	Months	Days	If less than one day
49	4	15	....hrs. ....min.

9. Birthplace: Ravenswood, W. Va.
(Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business:

FATHER — 12. Name: David H. McFarland

13. Birthplace: Mansfield, Ohio

MOTHER — 14. Maiden name: Ida Laughlin

15. Birthplace: West Virginia

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 6, 1946 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Fredk ave

18. Funeral director: Oden Funeral Home Inc

Address: 4644 York Road

19. 8/6 1946 (Date rec'd by registrar) A. W. HEDRICH Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1946, at 6:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1946, to August 3, 1946 and that I last saw him alive on August 3, 1946

Immediate cause of death	DURATION
Carcinoma of Sigmoid with metastases to liver and lung and peritoneal ~~xxx~~ implants	Unknown
Due to:	
Due to:	
Other conditions: Retroperitoneal abscess, post operative (2 weeks) Thrombosis of iliac vein, left.	

(Including pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

SIGNATURE: Robert M. Cullison M.D. or other

R. M. CULLISON, M.D. CLIN. DIRECTOR.

Address: V.A., Ft. Howard, Md. Date signed: 8-3-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93-D)

Registered No. P 37

07807

MARGIN RESERVED FOR BINDING

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Rodgers Forge
(b) Street address 1 Dunkirk Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Dunkirk Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel L. Mc Gonigle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1880

8. AGE: Years 65 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Mc Gonigle
13. Birthplace Ireland

MOTHER
14. Maiden Name M. Stark
15. Birthplace Ireland

16 (a) Informant Margaret Bullen
(b) Address 1 Dunkirk Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director John C Moran
(b) Address 3800 E Baltimore St

19 (a) AUG 19 1946 (Date rec'd by registrar) (b) A. W. Hedrick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Aug 17 1946, and that I last saw h[illegible] alive on Aug 16 1946.

Immediate cause of death	Duration
Myocardial Insufficiency	3 days
Due to Myocarditis	2 yrs.
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. White M. D.
Address 587 E. 22nd St Date signed 8/19/46

VS 150

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07808

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Merritt Ave. & North Point Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Sparrows Point Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Box #381, R. F. D. #10

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Barbara Meibohm

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or ~~wife~~ William Meibohm (deceased)

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1868

8. AGE: Years	Months	Days	If less than one day
78 yrs.			hrs. min.

9. Birthplace Germny (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Robert Meibohm - son

Address Merritt Ave. & North Point Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/46 (month) (day) (year)

Cemetery or crematory Trinity

Location O'Donnell St. Baltimore, Md.

18. Funeral director Charles E. Schimunek

Address 2601-03 E. Madison Street

19. 8/13/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1946, to Aug 11 1946, and that I last saw him alive on Aug 11 1946.

Immediate cause of death Lobar Pneumonia — DURATION 11 days

Due to

Due to

Other conditions Old age

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harry Lachman M.D.

M. D. or other

Address 2322 Callow Ave Date signed Aug 12, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

07809

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cockeys Mill Road.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Baldwin Henry Meyers

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	W

6.(b) Name of husband or wife Lillie May Dampman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1863

8. AGE: Years	Months	Days	If less than one day
82	9	17	..... hrs. ..... min.

9. Birthplace Fork Balto. Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Henry Meyers

FATHER 13. Birthplace Saxon, Germany

MOTHER 14. Maiden name Catherine Hoff.

MOTHER 15. Birthplace Germany

16. Informant Miss Bessie Meyers

Address Reisterstown.

17. Burial Date thereof Aug. 30, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Asbury

Location Reisterstown

18. Funeral director Wm Berryman & Sons

Address Reisterstown

19. Aug. 29, 1946 Mary B. Eline
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27/46 19..... at 1P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-30 to 8/27/46 19.....

and that I last saw h.. alive on 8/20/46 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to hypertension	
Due to arteriosclerosis	
Other conditions myocarditis	
(Include pregnancy within 3 months of death)	

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE James L. Duffield M. D. or other

Address Reisterstown Md Date signed 8/29/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ C7810 Reg. Dist. No. 44

1. PLACE OF DEATH:
County Balto
City or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Ebenezer Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto
City or town Whitemarsh
(If outside city or town limits, write RURAL and give nearest town)
Street No. Ebenezer Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary V. Meyers

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Martin J. Meyers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 24th 1879

8. AGE: Years	Months	Days	If less than one day
66			..... hrs. ..... min.

9. Birthplace Fredk. Co. Md.
(Town, county, and state)
10. Usual occupation at home
11. Industry or business

FATHER
12. Name August Geisey
13. Birthplace Fredk. Co. Md.

MOTHER
14. Maiden name Mary Roberts
15. Birthplace Fredk. Co. Md.

16. Informant Martin F. Meyers
Address Ebenezer Rd. Whitemarsh

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9 3 46 (month) (day) (year)
Cemetery or crematory Ebenezer Meth. Cem.
Location Balto. Co. Md.

18. Funeral director Lassahn Funeral Home
Address 7401 Belair Rd.

19. Aug 31 1946 (Date rec'd by registrar) John M. Gourley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1946, at 5-30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/31/46 19.. to ..... 19.....
and that I last saw h.. alive on 8/31/46 5:30 PM 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis & Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph D'Antoni M.D.
M. D. or other
Address 45-52 Clarks Rd. Date signed 9/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

07811 P

Reg. Dist. No. 4X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Sparrows Point.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Sparrows Point Hospital

How long in hospital or institution? 30 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State Md. County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5001 Beaufort ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Thomas E. Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 1905

8. AGE: Years 40 | Months 1 | Days 26 | If less than one day hrs. min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Bethlehem Steel Co

FATHER 12. Name John Morris

13. Birthplace Cumberland Md.

MOTHER 14. Maiden name Sadie Morris

15. Birthplace Cumberland Md.

16. Informant Mrs Rose Ward

Address 5001 Beaufort Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/46 (month) (day) (year)

Cemetery or crematory Cumberland

Location Cumberland Md.

18. Funeral director Wilhem Cook Inc

Address 214 E Pond St

19. 8/22 19 46 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 19 46 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	30 Min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Mclarmine M.D. Deputy Medical Examiner M. D. or Other

Address Cumberland Md. Date signed 8-22-1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07812 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
436 Ingleside Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 436 Ingleside Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LEONA PEARL MUSE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Robert L. Muse
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 14, 1870

8. AGE: Years	Months	Days	If less than one day
75	11	28	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George W. Crittenden
13. Birthplace: Va.

MOTHER
14. Maiden name: Columbia Cole
15. Birthplace: Va.

16. Informant: Mrs. Olive P. Maisel
Address: 436 Ingleside Ave., Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/14/46 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md.

19. 8/13/46 (Date rec'd by registrar) A. W. Hedrick DM Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 12, 1946, at 7:30a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 7, 1942, to August 12, 1946
and that I last saw h alive on August 11, 1946

Immediate cause of death	DURATION
Acute Myocardial Failure	10 min.
Due to: Chr. Hypertensive Cardio-vascular disease	10 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William K. Gallagher M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 8-12-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07813 Reg. Dist. No. 31

1. PLACE OF DEATH:
County: Balto
City or town: Granite
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 47 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md. County: Balto Co.
City or town: Granite
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Emma Nash

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: J Thomas Nash
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 29 - 1875

8. AGE: Years	Months	Days	If less than one day
70	10	25	hrs. min.

9. Birthplace: Alberton Balto Co Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Jesse Lee Bowers
13. Birthplace: Md
MOTHER 14. Maiden name: Emily Jane Upton
15. Birthplace: Md
16. Informant: Jesse Madeline Campbell
Address: 4827 Reisterstown Rd
17. Buried (Burial, cremation, or removal. Which?) Date thereof 8-26-46 (month) (day) (year)
Cemetery or crematory: Presbyterian Cemty
Location: Granite, Md.
18. Funeral director: H C Heyenbolthom
Address: Ellicott City Md
19. Aug. 25 1946 (Date rec'd by registrar) Vivie E Manley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1946, at 4:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1946, to August 23 1946
and that I last saw h.er alive on August 23 1946

Immediate cause of death	DURATION
Uremia glomerular nephritis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. B. Tortman M.D.
M. D. or other
Address: Ellicott City Md Date signed 8/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1875 70 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

07814

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State md. County Balto.
City or town Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 24 Chatsworth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Ida Virginia Naylor

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	S.

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1876

8. AGE: Years 69 | Months 8 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Yorkw. Balto. Md.
(Town, county, and state)

10. Usual occupation Dress maker

11. Industry or business —

FATHER 12. Name Amos Naylor
13. Birthplace Yorkw. Md.

MOTHER 14. Maiden name Emma Olivia Akehurst
15. Birthplace Mount Washington

16. Informant Mrs. Joshua Shipley
Address Deer Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 31, 1946 (month) (day) (year)
Cemetery or crematory Asbury.
Location Reisterstown

18. Funeral director Jos. Berryman & Sons
Address Reisterstown

19. Aug. 31 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-46 19 ..... at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-21-'44 19 ..... to 8-25-'46 19 .....
and that I last saw h alive on 8-25-'46 19 .....

Immediate cause of death	DURATION
Cerebral Vascular Decision	4 yrs
Due to arteriosclerosis	6 yrs
Due to	
Other conditions Hypertensive C.V. Disease	8 yrs

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of .....
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE D. D. Eagles, M.D.
M. D. or other
Address Reisterstown, Maryland Date signed 8-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(462)

07815

Reg. Dist. No. 42

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

1. PLACE OF DEATH:

County: Balto Co

City or town: Lansdowne

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Lansdowne Balto

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 1st Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edith Neilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow.

6.(b) Name of husband or wife: Ludwig M Oswald

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 10 — 1869

8. AGE:

Years	Months	Days	If less than one day
77	1	14	hrs. min.

9. Birthplace: Bristol England (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER

12. Name: John Owens

13. Birthplace: England

MOTHER

14. Maiden name: Mary Buckfield

15. Birthplace: England

16. Informant: Mrs P Selby Dissing

Address: 38 1st Ave Lansdowne

17. Burial: (Burial, cremation, or removal. Which?) Date thereof: 8/27/46 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Frederick Rd

18. Funeral director: Edw Toulson

Address: 2356 West Blvd

19. 8/26/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1946, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1946, to Aug 24 1946 and that I last saw h[illegible] alive on Aug 24 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	5 hrs.
Due to:	
Due to:	
Other conditions: Arteriosclerosis	long

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: A. C. Hearn M. D. or other

Address: 3901 Gwynns Falls Blvd

Date signed: 8/26/46

Evidence for the change of year of birth is shown on G 107/9/20/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH;
(a) Baltimore City, Maryland Raspeburg.
(b) Street address 1200 64th Street
(c) Hospital or institution: None
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED: 07816
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME George R. Neumann

3 (b) If veteran, name war No
3 (c) Social Security Account No. 212-03-4459

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24-1880

8. AGE: Years	Months	Days	If less than one day
65	7	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Upholstering Corp.

FATHER
12. Name Max Neumann
13. Birthplace Germany

MOTHER
14. Maiden Name Elise Hellick
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Florence Neumann
(b) Address 103 S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/46 (month) (day) (year)
(c) Cemetery or crematory Oak-Lawn
Location Eastern Ave - Extended

18 (a) Funeral director Lilly & Geiler, Inc.
(b) Address 403 S. Bolton Street

19 (a) 8/19/46 (Date rec'd by registrar) (b) H. M. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1946, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to Aug 1946, and that I last saw h.t.m alive on Aug 16 1946.

Immediate cause of death Cerebral Accident. — Duration 2 days
Due to Hypertension Cardio-Vascular Disease. — Duration 7 mo.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Flannigan Jr. M. D.
Address 3503 Fait ave Date signed Aug 19 46

Dr. Flannigan 3503 Fait Ave

VS A15 9-45-15M

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

P 07817

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 242 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Maryland
How long in hospital or institution? 242 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 916 McKean Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3.(a) FULL NAME: ROY G. NEWTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Ethel W. Newton
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): 7-1-1880

8. AGE:

Years	Months	Days	If less than one day
66	1	18	....hrs. ....min.

9. Birthplace: Owatona, Minn.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Eugene Newton
13. Birthplace: Minnesota

MOTHER
14. Maiden name: Anna Carpenter
15. Birthplace: Minnesota

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: Wm. J. Tickner & Sons
Address: North & Penn. Aves., Balto., Md.

19. 8/20 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19, 1946 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 19, 1945 to August 19, 1946 and that I last saw him alive on August 19, 1946

Immediate cause of death	DURATION
Pulmonary Emphysema	
Due to	
Due to	
Other conditions: Atrophy of the Hypophysis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: Same as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: Robert M. Cullinan
R. M. CULLINAN, M. D. CLIN. DIR.
Address: FT. HOWARD, MD. Date signed 8-19-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-a)

CERTIFICATE OF DEATH

07818

Reg. Dist. No. 31

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs., 10 mos., 19 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 2 yrs., 10 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George

City or town: Landover
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Robert Nicholas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emma Leebrick

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): February 20, 1884

8. AGE: Years	Months	Days	If less than one day
62	6	10	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Sheet metal worker

11. Industry or business: Metal

FATHER 12. Name: George L. Nicholas

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Louise Jane Phillips

MOTHER 15. Birthplace: Virginia

16. Informant: Hospital records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2-1946 (month) (day) (year)

Cemetery or crematory: Hyattsville

Location:

18. Funeral director: Francis Gaschenbong

Address: Hyattsville Md

19. 8-31 (Date rec'd by registrar) 1946 Harry D. Mullin Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 19 46, at 2:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
(a) Cor. Lanstrom	
Due to: (b) Manic depressive psychosis	
Due to: (c) Strangulated hernia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: De. J. McKieffer deceased Graham Ball M. D. or other

Address: 1010 Leeds ave Date signed: 8-30-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8a)

67819

CERTIFICATE OF DEATH

Reg. Diat. No. 31

1. PLACE OF DEATH:
County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur E. O'Dell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary J. Odell
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8th, 1871

8. AGE: Years	Months	Days	If less than one day
75	6	28	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name Edward C. Odell
13. Birthplace Maryland
MOTHER 14. Maiden name Emily Haviland
15. Birthplace New York
16. Informant Mrs. Mary J. Odell
Address Randallstown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 8th, 1946 (month) (day) (year)
Cemetery or crematory Wards Chapel
Location Liberty Road
16. Funeral director C. Harry Weer
Address Lyons Ville
19. 8/6/ 1946 (Date rec'd by registrar)
Wm. E. Martus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6th, 1946 19 at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1946, to Aug 6, 1946
and that I last saw him alive on Aug 5, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 wks
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. E. Martus M. D. or other
Address Randallstown Date signed 8/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07820

Reg. Dist. No. 53

1. PLACE OF DEATH:

County: Balto.

City or town: Glyndon

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 week

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: New Jersey County:

City or town: Woodcrest

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Geo. Wm Penn

3. (b) Social Security Number

148-03-8120

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Effie M. Penn

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 17, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	11	hrs. min.

9. Birthplace: Balto. Co. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: James H. Penn

13. Birthplace: Balto. Co.

MOTHER — 14. Maiden name: Elizabeth E. Nichols

15. Birthplace: Balto. Co.

16. Informant: T. Harry Penn

Address: Glyndon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1946 (month) (day) (year)

Cemetery or crematory: Reisterstown Methodist Cem.

Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons

Address: Reisterstown, Md.

19. Aug. 30 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1946, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-27 1946, to 8-27 1946 and that I last saw him alive on 8-27 1946

	DURATION
Immediate cause of death: Coronary Occlusion	2 min.
Due to: Hypertensive C-V Disease	10 yrs
Due to: Arteriosclerosis	5 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None. Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. D. Caples, M.D. med. Exam. M. D. or other

Address: Reisterstown, Md. Date signed: 8-28-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

Reg. Dist. No. 95

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
Flushing Ave.
How long in hospital or institution? Easter Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Flushing Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Reginald William Petre

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife: Caroline Preston
7. Birth date of deceased (mo., day, yr.): April 24, 1851
Apr 23 1851 B.(c) If alive, give age ..... years

8. AGE: Years	Months	Days	If less than one day
95	3	11	..... hrs. ..... min.

9. Birthplace: London England
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Frederick Petre
13. Birthplace: England

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Alexander Preston Petre
Address: 705 Spring Rd Towson Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7 1946 (month) (day) (year)
Cemetery or crematory: Green Mount
Location: Balto., Md.
18. Funeral director: Henry H. Jenkins' Sons
Address: McCulloh & Orchard Sts
19. 8/5 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1946, at 1.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 23 1945 to Aug. 4 1946
and that I last saw h... alive on Aug. 3 1946

Immediate cause of death	DURATION
Myocardial Insufficiency	2 yr.
Due to: Senility, Arteriosclerosis	3
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Wilmer F. Gallagher M.D.
(M. D. or other)
Address: Catonsville 28 Md. Date signed: 8-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (31-a)

★ Reg. Dist. No. 40 07822

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:

(a) County: Baltimore

(b) City or town: Middle River (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Ebenezer Rd Rpute 14 # 114

(d) Length of stay in hospital or inst. (yrs., mos., or days):

(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State: Maryland (b) County: Baltimore

(c) City or town: (If outside city or town limits, write RURAL and give town)

(d) Street No.: As in No 1 (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) FULL NAME: Lena Elizabeth Porter

3 (b) If veteran, name war:

3 (c) Social Security No.: -

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frederick M Porter

6. (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7/31/87

8. AGE: Years: 59 Months: - Days: 18 If less than one day: hr. min.

9. Birthplace: Carroll County Md (Town, county, and state)

10. Usual occupation: Processing Plant

11. Industry or business:

FATHER

12. Name: Henry Stumpf

13. Birthplace: Germany

MOTHER

14. Maiden Name: Nargaret Blum

15. Birthplace: Germany

16 (a) Informant: Mr Fredk M Porter

(b) Address: Ebenezer Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/46 (month) (day) (year)

(c) Cemetery or crematory: Zion Lutheran

Location: Stemmers Run

18 (a) Funeral director: Lassahn Funeral Home

(b) Address: 7401 Belair Rd Balto 6 Md

19 (a) 8/20/46 (Date rec'd by registrar) (b) W M Hammett Registrar

MEDICAL CERTIFICATION

20. Date of death Aug 18 1946, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1946, to Aug 18 1946, and that I last saw him alive on Aug 18 1946.

Immediate cause of death	Duration
Uraemia	1 month
Due to Chronic Nephritis	
Due to Arteriosclerotic Cardio vascular disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Geo. M Baumgardner M. D. or other

Address: Balto 6 Md Date signed 8-18-46

Evidence for change of age of deceased is shown on FILM No. I 06 SEP 10 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07823 44

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hours

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1503 N. Durham St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: EMIL C. RAUN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1892

8. AGE: Years	Months	Days	If less than one day
54	52- 1	4	hrs. min.

9. Birthplace: Chicago, Ill.
(Town, county, and state)

10. Usual occupation: Watchman

11. Industry or business:

FATHER
12. Name: Theodore Raun
13. Birthplace: Austria

MOTHER
14. Maiden name: Bertha Zamisch
15. Birthplace: Austria

16. Informant: Vets. Adm. Hosp. Clinical Records
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-12-46 (month) (day) (year)

Cemetery or crematory: Baltimore National

Location: Fredrick Ave.

18. Funeral director: Oder Funeral Home Inc.

Address: 4644 York Road.

19. 8/9 19 46 (Date rec'd by registrar) A W Wedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1946 at 2:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 1946 to August 8 1946 and that I last saw him alive on August 8 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	17 hrs.
Due to: Hypertension, Arterial	2 yrs. Plus
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: aor Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other

Address: Ft. Howard, Md. Date signed: 8-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4 transcript.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

67824

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore
City or town Middle River - Balto - co -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Tacoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 144 Carroll Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Hazel M. Redman

3. (b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Leon H. Redman
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 16 - 1899

8. AGE: Years 47 Months Days If less than one day ... hrs. ... min.

9. Birthplace Grand Rapids Mich
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business at home
FATHER 12. Name Leonard M Spear
13. Birthplace ?
MOTHER 14. Maiden name Nora Achor
15. Birthplace ?
16. Informant Leon H. Redman
Address 144 Carroll Av
17. Burial Date thereof 8/17/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Geo Washington Memorial
Location Edgar Rd - Mont Co. Md
18. Funeral director Lilly & Zeiler Co
Address 403 S. Wolfe St
19. 8/15 1946 A. W. Hedrick
(Date rec'd by registrar) Registrar
JW

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1946, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death Cerebral Hemorrhage	15 min
Due to Hypertensive C-V Disease	1 dy
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE J. M. B. Davis M.D.
Dept. Med. Examiner - Balto. Co
Address Dundalk 22 Md Date signed 8/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

07825 P

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 200 Linden Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 Linden Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME George F. Reimann

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Emelie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1868

8. AGE: Years 77 | Months 9 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Property Retired

11. Industry or business City of Baltimore

FATHER 12. Name Unknown

FATHER 13. Birthplace Germany

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Germany

16. Informant John Reimann Son

Address 200 Linden Ave Towson Md

17. Burial, cremation, or removal Burial Date thereof 8/21/46 (month) (day) (year)

Cemetery or crematory Woodlawn

Location Woodlawn Md

18. Funeral director Wilson & Son Inc

Address 214 E Lexington St

19. 8/20 1946 A. W. Hedrick Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1946 at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1945 to Aug 1946 and that I last saw h.. alive on August 19 1946

Immediate cause of death	DURATION
Coronary Thrombosis	1 wk.
Due to Arteriosclerotic Cardiovascular Renal disease	10 yrs.
Other conditions Hypertension	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles F. O'Donnell M. D. or other

Address 730 York Rd Date signed 8/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-A)

CERTIFICATE OF DEATH

07826

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs. 2 mos. 28 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 3 yrs. 2 mos. 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: —
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1216 Valley Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Augusta Renehan

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19, 1868

8. AGE:

Years	Months	Days	If less than one day
78	2	16	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Practical Nurse
11. Industry or business: Sanitarium

FATHER
12. Name: Joseph Renehan
13. Birthplace: Frederick County, Md.

MOTHER
14. Maiden name: Bridget McAvoy
15. Birthplace: Howard County, Md.

16. Informant: Hospital Records
Address: Catonsville 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-6-46 (month) (day) (year)
Cemetery or crematory: Carlin Dale
Location: Baltimore Md.

18. Funeral director: Guy A. Foley
Address: Catonsville Md

19. 8-5 1946 (Filed by registrar) Harry L. Miller Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1946, at 2:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1943, to Aug. 4 1946
and that I last saw h...r alive on Aug. 4 1946

Immediate cause of death	DURATION
Cerebral - Vascular Accident - Spontaneous Hemorrhage	4 days
Due to: Hypertension Cardio-Vascular Disease	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. .....
Autopsy results: Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gordon Funk, M. D. M. D. or other
Address: Spring Grove State Hosp. Catonsville 28, Md. Date signed 8-4-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07827

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 138 Clarendon Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gordon Lloyd Ritter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 8, 1946

8. AGE: Years	Months	Days	If less than one day
		18	hrs. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Calvin K Ritter
13. Birthplace: Baltimore Maryland
MOTHER 14. Maiden name: Edith L. Richardson
15. Birthplace: Baltimore Md
16. Informant: Calvin K Ritter
Address: 138 Clarendon Ave, Pikesville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 1946 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn Maryland
18. Funeral director: Frank L. Newcomer
Address: Pikesville 8 Md
19. 8-27-1946 (Date rec'd by registrar) Dr E E Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1946 at 3 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 26 1946 to Aug 26 1946 and that I last saw him alive on Aug 26 1946

Immediate cause of death	DURATION
Suffocation (accidental)	6 hrs.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
None.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accidental Date of: 8-26-'46
Where did injury occur? Pikesville, Balto Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: 13 da old baby lying on stomach Injured at work? No
Md

23. SIGNATURE: D. D. Caples, M. D. Examiner (M. D. or other)
Address: Reisterstown, Md Date signed: 8-26-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07828

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Balto.
City or town Fullerton.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: S. Baker ave.
How long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)
Street No. S. Baker ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Andrew Rudeling. **3.(b) Social Security Number** 213-03-9134

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Marie B.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 19 1895

8. AGE: Years 51 | Months 3 | Days 1 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto. Co. Md. (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Rudeling & Kunkle Co.
FATHER 12. Name John Rudeling
13. Birthplace Baltimore Md.
MOTHER 14. Maiden name Margaret Kloes
15. Birthplace Germany
16. Informant Mrs Marie B. Rudeling
Address South Baker Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/46 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore Md.
18. Funeral director J. Welch
Address 5305 Harford Rd.
19. 8/20 19 46 (Date rec'd by registrar) A W Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1946, at 6 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1946 to Aug 20 1946
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to Hypertension	
Due to Cerebral Hemorrhage	3 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J M Carmine M. D.
M. D. or other
Deputy Medical Examiner
Address ..... Date signed 8/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-C)

CERTIFICATE OF DEATH

C7829

Reg. Dist. No. .....

1. PLACE OF DEATH:
County BALTO. CO. MD.
City or town WOODLAWN
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
5531 CLIFTON AVE
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County BALTO.
City or town WOODLAWN
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5531 CLIFTON AVE
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME GRACE MARIE RUSSELL

3.(b) Social Security Number 212-26-2281

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 15, 1927

8. AGE: Years	Months	Days	If less than one day
19	3	21	..... hrs. ..... min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual occupation CLERK

11. Industry or business ARCHER LAUNDRY

FATHER
12. Name WILLIAM C. RUSSELL
13. Birthplace Md.

MOTHER
14. Maiden name ANNA MAY ROLEMAN
15. Birthplace BALTO CO. Md

16. Informant MRS ANNA MAY RUSSELL
Address 5531 CLIFTON AVE

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Aug 9 46
(month) (day) (year)
Cemetery or crematory Mt Olivet
Location Frederick Rd Balto Md

18. Funeral director WILLIAM COOK, INC
Address 1217 ST. PAUL ST.

19. 8/7 19 46 A.W. Tedrick
(Date rec'd by registrar) Registrar

S.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 19 46 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 19 42, to Aug. 6 19 46
and that I last saw h.. alive on August 5 19 46.

Immediate cause of death	DURATION
Rheumatic Cardio-vascular Disease	13yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations No operation
Date of op. .....
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Joshua H. Armacost MD
M.D. or other
Address 6419 Windsor Mill Rd Date signed Aug 6 1946
Baltimore Md

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

05830

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Balto.

City or town Essex

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address (where death occurred): Essex Police Sta. cell.

How long in hospital or institution? Several hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town 16 Pelzar ave.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Essex

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John N. Saddler. Saddler.

3.(b) Social Security Number 216-07-3701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife Marie L.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 29 - 1900

8. AGE:

Years	Months	Days	If less than one day
46	6	5	..... hrs. ..... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual occupation Chauffeur.

11. Industry or business

FATHER 12. Name Wm Saddler

13. Birthplace Balto Md

MOTHER 14. Maiden name Virginia Herbert

15. Birthplace Balto Md

16. Informant Marie L Saddler

Address 16 Pelzar Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6 1946 (month) (day) (year)

Cemetery or crematory Sacred Heart of Mary

Location Balto Co Md

18. Funeral director James J Budensiek

Address 4407 Eastern Ave Rd

19. 8/5 1946 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1946, at 6:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Strangulation by hanging	8 minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 8/4/46

Where did injury occur? Essex (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Hanging by belt Injured at work? No.

23. SIGNATURE J. M. Learmonth M.D. M. D. or other

Deputy Medical Examiner

Address Glenoak Md Date signed 8/4/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (171-a)

07831

CERTIFICATE OF DEATH

Reg. Dist. No. 4/4

1. PLACE OF DEATH:
County Balto.
City or town Furnes Station
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparrows Pt.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 "F" St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Geo. J. Schott.

3.(b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Irma
6.(c) If alive, give age 2 years
7. Birth date of deceased (mo., day, yr.) Oct. 12 1911
8. AGE: Years 34 Months 10 Days 3 If less than one day ... hrs. ... min.
9. Birthplace Balto. (Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Beth. Steel Sp. Pt.
FATHER 12. Name James Schott
13. Birthplace Balto.
MOTHER 14. Maiden name Mary Joenski
15. Birthplace Balto.
16. Informant Geo. Dieter
Address 415 "F" St. Sparrows Point
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-17-46 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Rd
18. Funeral director John J. Connelly
Address 418 Eastern Ave. Essex
19. 8/17/ (Date rec'd by registrar) 1946 John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1946 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: 1. Traumatic Evisceration of Abdominal Contents	
Due to: 2. Traumatic amputation left leg -	
Due to: 3. Shock due to injuries about	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8-15-46.
Where did injury occur? Dundalk - Balto Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury Run Over by Street Car Injured at work? No

23. SIGNATURE Dept. Med. Exam. - Balto Co. M.D. or other
Address Dundalk Md Date signed 8-16-46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

Reg. Dist. No. 07838

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Rogers Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Baltimore
City or town: Roger Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 209 Kegester Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louise Gwynn Scrivener

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Frank P. Scrivener
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 27 1872

8. AGE: Years	Months	Days	If less than one day
74	6	2	..... hrs. ..... min.

9. Birthplace: Brooklyn N.Y. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER 12. Name: Capt. A. J. Gwynn
13. Birthplace: Prince George Co Md
MOTHER 14. Maiden name: Marie Louise Keene
15. Birthplace: Dorchester Co Md
16. Informant: Mrs R. L. Bowie
Address: Upper Marlboro Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 31 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral Cem
Location: Balto Md
16. Funeral director: Henry W. Jenkins Sons
Address: McCulloh & Orchard Sts
19. 8/30/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/29 1946 at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1945, to Aug 29/ 1946
and that I last saw her alive on August 28 1946

Immediate cause of death	DURATION
Myocardial Insufficiency	7 days
Due to Myocarditis	9 mos.
Due to Arteriosclerosis Hypertension	2 yrs.
Other conditions Coronary Artery disease	9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas J Mackin M. D. or other
Address: 532 E 22nd St. Date signed 8/30/46

Dr. Thomas H Hute
532 E. 22nd St

9:30 to 11 a.m

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (746)

07833 P

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1307 N. Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-II

3.(a) FULL NAME: LEROY M. SEIGLE

3.(b) Social Security Number: 215-09-0144

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Exavah Seigle
6.(c) If alive, give age: 33 years

7. Birth date of deceased (mo., day, yr.): October 8, 1914 ?

8. AGE: Years	Months	Days	If less than one day
31	10	0	....hrs. ....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business

FATHER
12. Name: Henry Seigle
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Carrie Smith
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/12-46 (month) (day) (year)
Cemetery or crematory: Fourdon Church
Location: Frederick, Md.

18. Funeral director: Edward Toulson
Address: 2359 Washington Blvd. Balto. Md.

19. Aug 10 1946 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1946 at 6:10 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1 1946 to August 8 1946 and that I last saw him alive on August 8 1946

Immediate cause of death	DURATION
Acute Myeloid Leukemia	6 mos.
Due to	
Due to	
Other conditions: Severe hemorrhage in left frontal lobe of cerebrum & lt. lobe of cerebellum and brain stem	several hours

(Enter conditions, if any, giving rise to immediate cause of death)

Major findings of operations: ....Date of op. ....
Autopsy results: Substantiated as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: ....Injured at work?

23. SIGNATURE: Robert M. Cullison
ROBERT M. CULLISON, M.D. CLIN. DIR.
M. D. or other
Address: Ft. Howard, Md. Date signed: 8-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

FILM No. I O 6 AUG 22 1946

CERTIFICATE OF DEATH

07834 Reg. Dist. No. 44

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Balto.
City or town Dundalk. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 241 St. Helena Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Dundalk. (If outside city or town limits, write RURAL and give nearest town)
Street No. 241 St. Helena Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Millard L. Shipley
3.(b) Social Security Number

4. Sex M
5. Color or race W.
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Alice L. (nee Hickman)
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Aug. 28 – 1898

8. AGE: Years 47 Months 11 Days 19. If less than one day ... hrs. ... min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual occupation Conductor.
11. Industry or business Penn. Railroad.
FATHER 12. Name Herbert Wm. Shipley.
13. Birthplace Anne Arundel Co. Md.
MOTHER 14. Maiden name Grace Sandsbury.
15. Birthplace Anne Arundel Co. Md.
16. Informant Mrs. Alice L. Shipley.
Address 241 St. Helena Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/16/1946 (month) (day) (year)
Cemetery or crematory Oak Lawn.
Location Eastern Ave. Essex 21, Md.
18. Funeral director John G. Connelly.
Address 418 Eastern Ave. Essex 21, Md.
19. 8/24/ 1946 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12. 1946, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. B. Davis M.D. Dept. Med. Exam. – Balto. Co.
Address Dundalk–22–Md. Date signed 8-13-46

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. 331

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Int. Pleasant Sanatorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 weeks
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED: 07835
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Bentalou Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Aaron Silverman

3 (b) If veteran, name war

3 (c) Social Security No. 215-09-4959

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Anna Silverman

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1880

8. AGE: Years 66 | Months 1 | Days 17 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business

FATHER
12. Name Harry Silverman
13. Birthplace Poland

MOTHER
14. Maiden Name Rebecca Silverman
15. Birthplace Poland

16 (a) Informant Anna Silverman
(b) Address 1501 N. Bentalou Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-46 (month) (day) (year)
(c) Cemetery or crematory Wash Rd.
Location Wash Rd.

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Baltimore St

19 (a) 8/30/46 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death August 29, 1946 at 4 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2, 1946, to Aug. 29, 1946, and that I last saw him alive on Aug 29, 1946

Immediate cause of death	Duration
Myocardial Failure	
Due to Chronic Lymphatic Leukemia	3 years
Due to Pulmonary Tuberculosis	1 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Generalized Lymphadenopathy Enlarged Spleen & Liver Pulmonary TBC

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert F. Shorai M.D. (M. D. or other)
Address Pikesville, Md. Date signed 8/29/46

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (452)

07836

CERTIFICATE OF DEATH

Reg. Dist. No. 42

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred: 5507 Link ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Baltimore
City or town: Halethorpe
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5507 Link ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: George Edward Smith
3. (b) Social Security Number: 214-22-1480

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Katherine Becker Smith
6. (c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): July 9 - 1871

8. AGE:	Years	Months	Days	If less than one day
	75	0	30	hrs. min.

9. Birthplace: New Haven Conn.
(Town, county, and state)
10. Usual occupation: Pressman
11. Industry or business: Folding Box Co.

FATHER
12. Name: George Smith
13. Birthplace: Unknown

MOTHER
14. Maiden name: Isabelle Clark
15. Birthplace: Conn.

16. Informant: Mrs Katherine Smith
Address: 5507 Link ave Halethorpe (wife)
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10. 1946 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Frederick Ave - Baltimore, Md
18. Funeral director: G. Howard Strong
Address: 3707 W. North Ave.
19. 8/9 1946 A. W. Ledrick (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1946, at 8 P. M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 5 1946, to Aug 8 1946
and that I last saw him alive on Aug 8 1946

Immediate cause of death	DURATION
Carcinoma of rt mandible c	5 Mo
Due to: General carcinomatosis	5 yrs
Due to: Senility	3 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of mandible X Ray treatments Date of op.: May 1946
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 5609 main St. Date signed: 8/8/46

VS A15 9-45-15M

07837

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 123 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.

How long in hospital or institution? 123 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1008 Linden Ave., Balto., Md.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: GEORGE W. SMITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed

6.(c) If alive, give age: --

7. Birth date of deceased (mo., day, yr.): 1-4-1885

8. AGE: Years	Months	Days	If less than one day
61	7	25	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER
12. Name: Henry Smith
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Cora A.? Thomas
15. Birthplace: Baltimore, Md.

16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3-1946 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Md.

18. Funeral director: Robert Williams

Address: 1515 McElderry St., Balto., Md.

19. Sept 2 (Date rec'd by registrar) 1946 John D. Bruckly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1946, at 1:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 1946, to August 29, 1946 and that I last saw him alive on August 29, 1946

Immediate cause of death	DURATION
Diffuse Miliary Pul. Tuberculosis, bilateral, Rt. pleural effusion	Unknown
Due to:	
Due to:	
Other conditions: Arteriosclerotic endarteritis obliterans, Syphilis, latent	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. M.D.R. other

Address: V. A. Ft. Howard, Md. Date signed: 8-29-46

STATE OF MARYLAND—CERTIFICATE OF DEATH

07838

1. PLACE OF DEATH (467)

County Baltimore — Registration Dist. No. 32

Village or City Pikesville — No. 720 Howard Road St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Charles P. Sohn — If U. S. Veteran, specify WAR World War I

(a) Residence: No. 720 Howard Rd. St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Ethel Sohn

6. DATE OF BIRTH (month, day, and year): Nov. 10, 1890

7. AGE — Years	Months	Days	If LESS than 1 day, hrs. or min.
55	9	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Pharmacist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Drug Store

10. Date deceased last worked at this occupation (month and year): May - 1946

11. Total time (years) spent in this occupation: 35 yrs.

12. BIRTHPLACE (city or town) (State or country): Pittsburg Penna.

FATHER

13. NAME: Charles Sohn

14. BIRTHPLACE (city or town) (State or country): Pittsburg Penna.

MOTHER

15. MAIDEN NAME: Ida Hagel

16. BIRTHPLACE (city or town) (State or country): Pittsburg Penna.

17. INFORMANT: Mrs. Chas. Sohn. (Address) 720 Howard Road.

18. BURIAL, CREMATION, OR REMOVAL: Place Burial Baltimore National Cemetery Date Aug 26, 1946

19. UNDERTAKER: Harry L. Mistle (Address) 4101 Edmondson Ave.

20. FILED 8/24, 1946 — A. W. Hedrick Registrar. A.S.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August 23. (Month) (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 15, 1946, to Aug 23, 1946

I last saw him alive on Aug 21, 1946; death is said to have occurred on the date stated above at 9:30 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Pancreas with metastases	Feb. 1946

Other Contributory Causes of importance:

Name of operation Exploratory — Date of 5/4/46

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) Dawes Brown M. D.

(Address) 1665 W. North Ave. Balto. Md.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

07839

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4 Butler Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME William Thomas Sprinkle

3. (b) Social Security Number 219-12-9773

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	M.

6.(b) Name of husband or wife Theresa Ann Lindvall
6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) March 12, 1886

8. AGE:

Years	Months	Days	If less than one day
60	5	18	hrs. min.

9. Birthplace Reisterstown, Balto. md.
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
12. FATHER Name John George Sprinkle
13. Birthplace Pleasant Grove, md
14. MOTHER Maiden name Mary Frances Turnbaugh
15. Birthplace Owings Mills
16. Informant William Thomas Sprinkle Jr.
Address Glyndon, md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1946 (month) (day) (year)
Cemetery or crematory Asbury
Location Reisterstown
18. Funeral director Wm Berryman & Sons
Address Reisterstown
19. Aug-31-1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946 at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-22 1938, to 8-30 1946 and that I last saw h— alive on Aug 30 1946.

	DURATION
Immediate cause of death Metastatic Carcinoma of the Brain	1 mo.
Due to Ca. of Sigmoid	2 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operation Ca. of Sigmoid
Date of op. 1-23-'45
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. D. Eagles, M.D. M. D. or other
Address Reisterstown, Md Date signed 8-31-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07840

Reg. Dist. No. 33

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Balto

City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Ten weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll

City or town Finksburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war — ✓

3.(a) FULL NAME Margaret Doolan Steffey

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife Millard F. Steffey

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 24, 1868

8. AGE: Years 78 Months 0 Days 28 If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Doolan

13. Birthplace Ireland

MOTHER 14. Maiden name Bridget Kelly

15. Birthplace Balto.

16. Informant Howard F. Wells

Address Glyndon, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 26, 1946 (month) (day) (year)

Cemetery or crematory Finksburg

Location Finksburg, Md.

18. Funeral director Wm. Brayman & Sons

Address Reisterstown, Md

19. August 23 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1946, at 2:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-5 1946, to 8-22 1946 and that I last saw h.. alive on 21 1946

Immediate cause of death	DURATION
Carcinoma of Colon	18 mo. (estimated)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Eaples, M. D.
M. D. or other

Address Reisterstown, Md. Date signed 8-23-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 07841 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?:
Hospital, institution, or street address where death occurred:
Hood Nursing Home 5501 Edmondson Avenue
How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5501 Edmondson Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: BARBARA STICKS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Mathew
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years	Months	Days	If less than one day
About 77			hrs. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Michael Klein
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Joseph G. Young
Address: Reisterstown Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 7, 1946 (month) (day) (year)
Cemetery or crematory: Sacred Heart Cemetery
Location: Baltimore, Co. Maryland

18. Funeral director: William Cook, Inc.,
Address: 1217 St. Paul Street

19. 8/6 1946 A. W. Hedrick Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 5 1946 at 8 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1946 to Aug 5 1946 and that I last saw h... alive on Aug 5 1946

Immediate cause of death	DURATION
Pul. Thyocardosis	1 mon
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Catonsville Date signed: 8-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

07842

Reg. Diat. No. 44

1. PLACE OF DEATH:

County Balto

City or town Long Beach Middle River

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Middle River

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Wm. Swearingen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 - 1931

8. AGE: Years	Months	Days	If less than one day
15			hrs. min.

9. Birthplace W Virginia (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Charles A. Swearingen

13. Birthplace Penna.

MOTHER 14. Maiden name Arlene Zinger

15. Birthplace W Va.

16. Informant Charles A Swearingen

Address Long Beach Middle River

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8 17 46 (month) (day) (year)

Cemetery or crematory Mayfield Park.

Location Balto Co.

18. Funeral director James F Buzgevicke

Address 1401 Eastern Ave.

19. 8/14 1946 (Date rec'd by registrar) A. W. Hebert M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1946, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Drowning Accidental	
Due to Found 8/13/46	- 8 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of injury 8/13/46

Where did injury occur Middle River (City or town) Balto (County) Md. (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Drowning Accident Injured at work? No.

23. SIGNATURE W M Learning M.D.

Deputy Medical Examiner M.D. or other

Address Balto Md Date signed 8/14/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

CERTIFICATE OF DEATH

★ 07843

Reg. Dist. No. 37

1. PLACE OF DEATH:
County Baltimore
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Sparks
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Joseph Pembroke Thom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Margaret Sterling Thom
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) April 23, 1873

8. AGE: Years	Months	Days	If less than one day
73	3	17	hrs. min.

9. Birthplace Balto. City
(Town, county, and state)
10. Usual occupation Lawyer
11. Industry or business
FATHER 12. Name Dr. Joseph P. Thom
13. Birthplace Virginia
MOTHER 14. Maiden name Catherine Reynolds
15. Birthplace Kentucky
16. Informant Mrs. J. Pembroke Thom
Address Sparks, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8 12 46 (month) (day) (year)
Cemetery or crematory Greenmount
Location Greenmount Ave, Balto
18. Funeral director J. Scott Brooks
Address Sparks, Md.
19. Aug. 11 46 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1946 at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1944 to Aug. 9 1946
and that I last saw h/l/M alive on Aug. 9 1946

Immediate cause of death	DURATION
Chronic myocarditis	2yr.
Due to	
Due to	
Other conditions generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. M. France M. D., or other
Address Parkton, Md. Date signed 8/11/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07844

★ Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yrs., 7 mos., 15 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 1 yrs., 7 mos., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 721 Highwood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James G. Tierney

3.(b) Social Security Number: 215-07-6778

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 9, 1904

8. AGE: Years	Months	Days	If less than one day
41	8	17	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Manager in Shirt Factory.

11. Industry or business:

FATHER
12. Name: George J. Tierney
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary Freburger
15. Birthplace: Baltimore, Maryland

16. Informant: James G. Tierney
Address: 721 Highwood Drive, Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 29, 1946 (month) (day) (year)
Cemetery or crematory: Moreland Park
Location: 5806 Harford Rd., Balto., Md.

18. Funeral director: William Cook, Inc.
Address: St. Paul & Preston Sts., Balto., Md.

19. Aug. 26 1946 (Date rec'd by registrar) Earl T. Webster Registrar

Rec'd 8-28-46 Dr. E. E. Nichols

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 1946, at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11, 1945, to August 26, 1946 and that I last saw him alive on August 26, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10 Yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: No operation
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. D. Siegel M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 8/26/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

07846

Reg. Dist. No. 35

1. PLACE OF DEATH:

County Baltimore

City or town White Hall Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town White Hall Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Jennie C. Troyer

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

B.(b) Name of husband or wife Lewis Troyer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 27. 1863

8. AGE: Years	Months	Days	If less than one day
83	11	24	..... hrs. ..... min.

9. Birthplace Phoenix Md
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name John Malcom

13. Birthplace Unknown

MOTHER 14. Maiden name Mary Barger

15. Birthplace Unknown

16. Informant Mrs. Helen Troyer

Address White Hall. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 28-46 (month) (day) (year)

Cemetery or crematory Wesley chapel

Location Monkton R.F.D. Md

18. Funeral director Howard S. Mathews

Address White Hall. Md

19. Aug. 23 1946 Mrs Howard S. Mathews
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946 at 3:45 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19.46 to Aug 21 19.46

and that I last saw h.. alive on Aug 21 19.46

Immediate cause of death	DURATION
Cerebral Thrombosis	5 days
Due to	
Due to	
Other conditions Hypertension generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. W. France M. D. or other

Address Parkton, Md Date signed 8/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07847

Reg. Dist. No. 4X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Hosp., Ft. Howard, Md.
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1006 W. Franklin St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: HARRY TRUSTY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Mary M. Trusty
6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): 5-5-94

8. AGE: Years	Months	Days	If less than one day
52	3	23	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:
FATHER 12. Name: William Trusty
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Jacobs
15. Birthplace: Virginia
16. Informant: Clinical Records, Vets. Adm. Hosp.
Address: Ft. Howard, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/46 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.
18. Funeral director: Mr. Charles Cooper
Address: 510 - 512 N. Carrlton Ave., Balto., Md.
19. 8/31/46 (Date received by registrar) A. K. Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28, 1946 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23, 1946 to August 28, 1946 and that I last saw him alive on August 28, 1946

Immediate cause of death	DURATION
Carcinoma of Prostate, Far adv. with metastasis to liver, spine and long bones	1-1/2 Yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R. M. CULLISON, M.D. CLIN. DIR. M.D., other
Address: V. A. Ft. Howard, Md. Date signed 8-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

07848 41 8

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Dundalk - 22 - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 weeks

Hospital, institution, or street address where death occurred:

107 Dundalk Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvania County: Allegheny

City or town: Pittsburgh

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1312 Lowrie St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie Marie Tysinger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Arthur Tysinger

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 April 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Berlin, Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER 12. Name: Jacob Minkau

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Marie Hahn

MOTHER 15. Birthplace: Germany

16. Informant: Mrs. Lena Novak

Address: 107 Dundalk Ave

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 2 1946 (month) (day) (year)

Cemetery or crematory: Millvale

Location: Pennsylvania

18. Funeral director: Welsh Funeral Home

Address: 2008 Orleans St

19. 8 Aug 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 August 1946 at 8:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 July 1946 to 1 August 1946 and that I last saw her alive on 29 July 1946

Immediate cause of death	DURATION
Bronchial asthma	40 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Bernard W. Pollock M. D. or other

Address: 8 Liberty Parkway Dundalk-Md Date signed: Aug. 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07849

Reg. Dist. No. 45

1. PLACE OF DEATH:

County: Baltimore County

City or town: Kingsville Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Belair Rd North of Kingsville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.: As in No 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Louisa K Unkart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas Unkart

Baltimore County Md — If alive, give age: ~~XXX~~ 68 years

7. Birth date of deceased (mo., day, yr.): 10/29/77

8. AGE: Years	Months	Days	If less than one day
68	9	19	..... hrs. ..... min.

9. Birthplace: Baltimore County Md
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER — 12. Name: George Klass

13. Birthplace: Germany

MOTHER — 14. Maiden name: Wilhelmina Grill

15. Birthplace: Baltimore City Md

16. Informant: Mr Thomas Unkart

Address: Belair Road Hydes P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/20/46 (month) (day) (year)

Cemetery or crematory: St Pauls Cemetary

Location: Kingsville Md

18. Funeral director: Lassahn Funeral Home

Address: 7401 Belair Rd Balto 6 Md

19. 8/18/46 (Date rec'd by registrar) 19.... J D Kimmett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 1946 at 830 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1946 to Aug 17 1946 and that I last saw her alive on Aug 17 1946

Immediate cause of death	DURATION
Cancer of Liver	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca Liver

Date of op. Feb 1946

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Fred O Hodous, M.D.
M. D. or other

Address: Edgewood Md Date signed: 8-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

07850 P

CERTIFICATE OF DEATH

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Balto

City or town Colegate 24

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, Institution, or street address where death occurred:

401 E. 52nd St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Colegate 24

(If outside city or town limits, write RURAL and give nearest town)

Street No. 401 E. 52nd St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna Barbara Vogel

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widow

6.(b) Name of husband or wife George A. Vogel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1861

8. AGE:

Years	Months	Days	If less than one day
85	7	3	..... hrs. ..... min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER 12. Name George Eberly

13. Birthplace Germany

MOTHER 14. Maiden name Margaret

15. Birthplace Germany

16. Informant Calvin A. Vogel

Address 401 E. 52nd St

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1946 (month) (day) (year)

Cemetery or crematory Oak Lawn

Location Colgate Md

18. Funeral director Kilby's Funeral Home

Address 2008 Orleans St.

19. 8/31 1946 A. W. Hedrick Jr. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1946 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 30 1946 to Aug 30 1946

and that I last saw h[illegible] alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 hrs.
Due to (a) Paralysis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. M. Bearman M.D. M.D. or other

Deputy Medical Examiner

Address Dundalk, Md. Date signed 9/1/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

07851

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs., 11 mos., 28 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 33 yrs., 11 mos., 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jennie Wales

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1871?

8. AGE: Years	Months	Days	If less than one day
74	?	?	hrs. min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

18. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-46 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. 8-5- 1946 (Date rec'd by registrar) Harry A. Mueller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1946, at 6:20 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hypostatic Pneumonia	12 hrs
Due to: fractured left hip	
Due to: accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide? Accident Date of July 29 '46

Where did injury occur? Catonsville Baltimore Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Hospital

Means of injury: Pushed down by another patient Injured at work? no

How injured: [illegible]

23. SIGNATURE: Geo. W. Kieffer Jr. M.D. M.D. or other

Address: 1010 Leeds ave Baltimore Md Date signed: Aug 5 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52

CERTIFICATE OF DEATH

Reg. Dist. No. 07852 35

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since May 14th, 1913.
Hospital, institution, or street address where death occurred:
Springe Grove State Hospital
How long in hospital or institution? since May 14th, 1913.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 S. Kresson Str.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American ✓

3.(a) FULL NAME: William H. R. Walter

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 68 | Months: unknown | Days: | If less than one day: hrs. min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: William Henry Walter
13. Birthplace: unknown

MOTHER
14. Maiden name: Eliza Durm
15. Birthplace: unknown

16. Informant: hospital record
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/46 (month) (day) (year)
Cemetery or crematory: Baltimore
Location: Baltimore Md
18. Funeral director: Wilson Coh Inc
Address: 1217 E Fayette St.

19. 8/5 46 (Signature of registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3rd 19 46, at 12.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14th, 1913 19 to 8.3.1946 19 and that I last saw h im alive on 8.3.46 19

Immediate cause of death: Papillary carcinoma of bladder with metastasis to bones — DURATION: 2yrs

Due to:

Due to:

Other conditions: pyelo-nephritis, right.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Andrew Funk M.D. (M. D. or other)
Address: Spring Grove Hospital Date signed: 8.3.46.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 2 mos., 1 day
Hospital, Institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 2 mos., 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8863 Piney Branch Road
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs. Margureat M. Willard

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George M. Willard
6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 22, 1913

8. AGE: Years	Months	Days	If less than one day
33	1	1	...hrs. ...min.

9. Birthplace: Pittsburgh, Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: John W. Rush
13. Birthplace: Ohio

MOTHER
14. Maiden name: Mary R. Campbell
15. Birthplace: Ohio

16. Informant: Mrs. Margureat M. Willard
Address: 8863 Piney Branch Rd., Silver Springs, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1946 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Fort Lincoln, Maryland

18. Funeral director: Frank Newell
Address: Pikesville, Maryland

19. Aug. 23, 1946 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23, 1946, at 11:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1946 1946, to August 23, 1946 and that I last saw her alive on August 23, 1946

Immediate cause of death	DURATION
Active Pulmonary Tuberculosis	6 Years
Due to: Tubercle Bacilli	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: B. D. Siegel M.D. (M. D. or other)
Address: Mount Wilson, Md. Date signed: 8/23/46

Rec'd 8-27-46 Dr. E E Nichols mm

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Todd Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore

City or town Fort Howard Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Todd Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harriett E. Williams

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Edwin S.

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1884

8. AGE:

Years	Months	Days	If less than one day
62	3	10	hrs. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Milliner

11. Industry or business

FATHER

12. Name Emit Manns

13. Birthplace At Sea

MOTHER

14. Maiden name Henrietta Brandanburg

15. Birthplace Ohio

16. Informant Marion E. Devers

Address Fort Howard, Md.

17. Removal Date thereof 8/13/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodland

Location Cleveland, Ohio

18. Funeral director Wm. Cook Inc.

Address 1217 St Paul St.

19. Aug 12 1946 Dawson E. Harbin

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1946, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1946, to Aug 11 1946, and that I last saw h-- alive on Aug 11 1946.

	DURATION
Immediate cause of death: Acute Congestive Heart failure	3
Due to: Arteriosclerotic Heart Dis.	7 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Belinder, M.D.

M. D. or other

Address 520 D St. Sp Ft G Md Date signed 8-10-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07855

Reg. Dist. No. 42

1. PLACE OF DEATH:
County Balto
City or town Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Linden Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Relay
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1608 Linden Lane
(If rural, give LOCATION)
2.(a) If veteran, name war Spanish American and World War #1

3. (a) FULL NAME Richard Henry Dunning Willis
3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Rose E. Willis
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov 7th 1862

8. AGE: Years	Months	Days	If less than one day
83	9	23	... hrs. ... min.

9. Birthplace: Balto Md
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Richard H. Willis
13. Birthplace: Md.

MOTHER
14. Maiden name: Anna E. Weaver
15. Birthplace: Md

16. Informant: Richard H. Willis
Address: 1608 Linden Lane - Relay Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 9/3/46
(month) (day) (year)
Cemetery or crematory: U. S. National
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 1217 St. Paul St.

19. 9-3 46 [signature]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1946, at 4-30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Exhaustion
Due to
Due to: Exposure to Elements
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Geo. J. McKieffer
Deputy Med. Examiner Balto Co.
M. D. or other
Address: 1010 Leeds ave
Date signed Aug 31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-2)

CERTIFICATE OF DEATH

07856 33

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Reisterstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 20 Sacred Heart Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edna Wimple

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married.

6.(b) Name of husband or wife: Russell Wimple

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 2-25-1893

8. AGE: Years	Months	Days	If less than one day
53	6	—	...hrs. ...min.

9. Birthplace: Calvert County Md (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Edward Gross

13. Birthplace: Md

MOTHER — 14. Maiden name: Elizabeth Gladden

15. Birthplace: Md

16. Informant: Russell Wimple

Address: 20 Sacred Heart Lane

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-1-46 (month) (day) (year)

Cemetery or crematory: St. Lukes Cemetery

Location: Reisterstown Md

18. Funeral director: William A Jackson

Address: 916 Baltimore-1- Md

19. 8/29/46 (Date rec'd by registrar) Confidential Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1946, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-26 1946, to 8-28 1946, and that I last saw her alive on 8-27 1946

Immediate cause of death	DURATION
Hypertensive C-V. Disease	6 mo
Heart Block	1 mo
Due to: Obesity	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples M.D. M. D. or other

Address: Reisterstown, Md. Date signed: 8-28-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

Reg. Diat. No. 178537 8

1. PLACE OF DEATH:
County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life - 5 hrs. - 40 mins.
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Texas
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Railroad Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Female Winder

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 31 August 1946

8. AGE: Years | Months | Days | If less than one day: 5 hrs. 40 min.

9. Birthplace: Texas Balt. Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Earl Whyc
13. Birthplace: Texas, Md.

MOTHER
14. Maiden name: Clara E. Winder
15. Birthplace: Cockeysville Md.

16. Informant: Clara E. Winder
Address: Texas Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9 7 46 (month) (day) (year)
Cemetery or crematory: Basil M. E.
Location: Cockeysville, Md.

18. Funeral director: L. Scott Brooks
Address: Sparks, Md.

19. Aug. 31 46 (Date rec'd by registrar) Wilmer C. Ensor, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 August 1946 at 10:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 August 1946 to 31 August 1946 and that I last saw her alive on 31 August 1946

	DURATION
Immediate cause of death: Prematurc	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work?

23. SIGNATURE: Walter T. Kees M D (M. D. or other)
Address: Cockeysville, Md Date signed: 31 Aug 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dept doc to Henry Wilson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 07858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Fort Howard, Md.
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 mos. 6 days
Hospital, institution, or street address where death occurred:
Vets. Adm. Hosp. Ft. Howard, Md.
How long in hospital or institution? 11 mos. 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 908 W. Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war WWI

3. (a) FULL NAME
George M. Wright

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Bessie Wright
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) July 16, 1887

8. AGE:

Years	Months	Days	If less than one day
59	1	9	...hrs. ...min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Clinical Records, Vets.Adm. Hosp.
Address Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28 1946 (month) (day) (year)
Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.

18. Funeral director Elroy O. Wilson
Address 1000 Brantley Ave., Balto., Md.

19. 8/28 1946 [illegible] Registrar
(Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1946 19... at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 18 19 45, to Aug. 25 19 46 and that I last saw him alive on Aug. 25 1946

Immediate cause of death	DURATION
Hypertensive & Arteriosclerotic heart disease; Myocardial insufficiency; Auricular Fibrillation	2 yrs
Due to	
Due to	
Other conditions Nephrosclerosis	uhkhown
Syphilis, latent, late	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... injured at work?

23. SIGNATURE Robert M. Cullison
RM CULLISON, M.D. CLIN. DIR.
M. D. or Other
Address V.A.H. Ft. Howard, Md. Date signed Aug. 25, 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

P 07859

(932)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Baltimore

City or town Bradshaw

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Bradshaw Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME HARRISON YANCEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Sidonia Yancey

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	6	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Ned Yancey

13. Birthplace Va.

MOTHER 14. Maiden name Amanda ?

15. Birthplace ?

16. Informant Mrs. Sarah Haynes

Address 704 N. Gay Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 27-46 (month) (day) (year)

Cemetery or crematory Mt. Auburn Cem.

Location Baltimore, Md.

18. Funeral director Mrs. Frances A. Hemsley

Address 578 W. Biddle St.

19. 8/28 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1946, at 845P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,

and that I last saw h alive on 19,

Immediate cause of death CORONARY OCCLUSION — DURATION

Due to HYPERTENSIV CARDIOVASCULAR DISEASE

Due to ARTERIOSCLEROTIC DISEASE

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Stephen C. Mackowiak

Asst. Deputy medical examiner

Address 6714 HOLABIRD AVE Date signed Aug 27, 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-B

CERTIFICATE OF DEATH

07860

Reg. Dist. No. 30

P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Balto.

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:

Opitz Home, Edmondson Ave. & Nunnery Lane

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 Admiral Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARY ELLA YOUNKER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles A. Younker

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 12, 1859

8. AGE: Years	Months	Days	If less than one day
86	11	10	hrs. min.

9. Birthplace: Balto. Co., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Gambrill Knight

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Jane Powley

15. Birthplace: Md.

16. Informant: Mrs. William H. Haines

Address: 1 Admiral Blvd., Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/24/46 (month) (day) (year)

Cemetery or crematory: Moreland Memorial Pk.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 8/24 1946 (Date rec'd by registrar) A.W. Hedrick per HHS Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 22, 1946, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to Aug 22 1946, and that I last saw h alive on Aug 22 1946.

	DURATION
Immediate cause of death: Vertebrae Astrom Tuberous	1 yr
Due to:	
Due to:	
Other conditions: Hepar Trophic Arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Catonsville Date signed: 8/25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

07861

CERTIFICATE OF DEATH

Reg. Diat. No. 33

1. PLACE OF DEATH:

County: Baltimore

City or town: Glyndon, Maryland, Worthington Valley
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? entire life.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rural Glyndon, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Worthington Valley
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Henry Zouck.

3.(b) Social Security Number: none -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male.	white	married

6.(b) Name of husband or wife: Nellie Dempwolf

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Aug. 6 1879

8. AGE: Years	Months	Days	If less than one day
67		7	....hrs. ....min.

8. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Lumber Business- and

11. Industry or business: Farmer.

FATHER
12. Name: Henry J. Zouck
13. Birthplace: Balto Co.

MOTHER
14. Maiden name: Martha Millender
15. Birthplace: Balto. Co

16. Informant: Nellie Dempwolf Zouck
Address: Glyndon, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug - 16 - 46 (month) (day) (year)

Cemetery or crematory: St Johns Church

Location: Worthington Valley, Glyndon, Md.

18. Funeral director: J. F. Eline Sons

Address: Reisterstown, Maryland

19. 8 - 16 1946 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13, 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1937, to Aug 1946 and that I last saw him alive on 3 August 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension and Atherosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: none (no autopsy)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Walter L. Kinkenwerder
M. D. or other

Address: 1014 St Paul St Baltimore, Md. Date signed: Aug 15, 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING